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ABSTRACT

This publication contains the reports of two major public advisory bodies which studied and conducted hearings on mental health needs of the elderly and developed recommendations for public policy to address these needs. The first report reviews current mental health needs and considers the projected needs for dealing with emotional stress during the next 25 years and lists seven recommendations for public policy based on existing laws and institutions. The second report deals with future needs of mental health facilities, manpower training and research, the appropriate care of the elderly in mental institutions, and proposals for implementing recommendations from the 1971 White House Conference on Aging about mental health of the elderly. (JAC)

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ED216303

MENTAL HEALTH AND THE ELDERLY

RECOMMENDATIONS FOR ACTION

THE REPORTS OF:

THE PRESIDENT'S COMMISSION
ON MENTAL HEALTH: TASK PANEL ON THE ELDERLY

THE SECRETARY'S COMMITTEE
ON MENTAL HEALTH AND ILLNESS OF THE ELDERLY

DHEW Publication No.(OHDS) 80-20960

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Federal Council on the Aging

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INTRODUCTION

The Federal Council on the Aging, as a public service, and in recognition of the import of the subject to the health and well-being of the Nation's elderly is pleased to publish this report: Mental Health and the Elderly: Recommendations for Action. The publication contains in one document the reports of the two major public advisory bodies which during the period 1976-1978 studied and conducted hearings on the issue of the mental health needs of the elderly and developed recommendations for public policy to address these needs.

The Secretary's Committee on the Mental Health and Illness of the Elderly was established by Congressional mandate for one year's duration to conduct a study and make recommendations to the Secretary of H.E.W. for submission to the Congress in three areas: 1) the future needs for mental health facilities, manpower, research and training to meet the mental health needs of elderly persons, 2) the appropriate care of elderly individuals who are in mental institutions or who have been discharged from such institutions, and 3) proposals for implementing the recommendations of the 1971 White House Conference on Aging. The report was transmitted on May, 1978.

The Presidential Commission on Mental Health, established by Executive Order in February, 1977 and a broader mandate: to review the mental health needs of the Nation as a whole and to make recommendations to the President as to how the Nation might best meet these needs. Special task panels made up of the Nation's foremost authorities in mental health were formed to address areas of specialized need. The report of the Task Panel on the Elderly is presented in this FCA publication.

While publication of the two reports comprising the present document does not entail endorsement by the Council of the individual recommendations, we believe the overall thrust of the recommendations provides the framework for a comprehensive national policy on mental health and the elderly. We are, therefore pleased to present this report as part of the FCA's on-going policy of publishing and disseminating documents of vital importance in the field of aging.

Nelson H. Cruikshank, Chairman
Federal Council on the Aging

Date: November 1, 1979

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REPORT OF THE TASK PANEL
ON
MENTAL HEALTH OF THE ELDERLY

SUBMITTED TO
THE PRESIDENT'S COMMISSION ON MENTAL HEALTH

February 15, 1978

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Although the Commission has adopted certain of the options proposed by the task panels, the opinions and recommendations contained in the panel reports should be viewed as those of the panel members; they do not necessarily reflect the views of the Commission. Rather, their publication is intended to share with the public the valuable information these individuals so generously contributed to the Commission.

EXECUTIVE SUMMARY

The explosion in absolute numbers and relative proportions of older people represents a human triumph. What it really means is that women no longer die in childbirth, children no longer die at birth and in childhood, and for the first time we have the opportunity for great numbers of three- or even a multigenerational families.

This dramatic change in demographics, however, also means there are adjustments that have to be made.

One of the Commission's charges is to determine who are among the underserved. Certainly children are; certainly older people are. The field of geriatrics, gerontology, and mental health of the aged has been a very undernourished one. The problems are massive: depression escalates decade by decade; 25 percent of all the suicides are committed by people over 65 years of age; we face the devastating organic brain syndrome; we face all the same crises in everyday problems that people of all ages do, if not more so. Yet, less than 3 percent of the budget of the National Institute of Mental Health has been devoted to the totality of services, training, and research on the plight of the older Americans.

Another charge of the Commission is to consider the projected needs for dealing with emotional stress during the next 25 years. By then, we will have an enormous number of Americans on the brink of old age. By the years 2020-2030, as many as one out of every five Americans will be over 65.

The extent, incidence, and prevalence of emotional and mental problems in later years have been seriously underestimated. This is because statistics have depended upon utilization rates in community hospitals and mental health centers, and older people have been systematically excluded from and transferred out of public mental hospitals into communities ill-prepared to care for them. This has kept older people and their problems outside the mainstream of the best of American medicine in the mental health care system.

The burden does not fall only upon older people but on their families--their middle-aged children and their grandchildren as well. The middle-aged bear the responsibility of supporting both ends of the life cycle; they feel the pain of forced choices between helping their parents or helping their children.

Our panel carefully, deliberately, and quite conservatively selected seven major and cost-effective options. We wanted to be realistic. We have made use of what already exists on the books legislatively and have built not only upon existing legislation but also upon existing institutions: the National Institute of Mental Health (NIMH), the National Institute of Aging (NIA), the Social Security Administration (SSA), and the Administration on Aging (AoA).

The following seven options are all relevant to prevention and cost containment. They are not presented in order of priority; we believe each to be equally important steps which should be incorporated simultaneously. These efforts, if adopted, will contribute to the welfare of children who need a humanistic vision of their grandparents and of the later years and who will profit from new knowledge gained through our understanding of the great integrative systems of the body as they change with time and in relationship to age. The traits of a gifted type of adaptation and a wondrous type of survival seen among older people have application to children.

1. Outreach: The problem of accessibility can be ameliorated using an outreach approach, with a coordinator integrating the various services available within the community.

2. Home Care: Home care must become an essential component of the continuum of mental and physical health care of the elderly.

3. Medicare: The discriminatory treatment of mental health services under the provisions of Medicare must be reformed to reduce expensive institutionalization which results from the way current legislation is written.

4. Geriatric Medicine: Geriatric training must become a part of the mainstream of knowledge in preparing doctors, nurses, social workers, and psychologists.

5. Research: There must be a major national effort to promote and support accelerated research on the single most terrifying mental health problem of the elderly--organic brain diseases.

6. Allocation of Resources: Resources within the Department of Health, Education, and Welfare (HEW) especially in NIMH and NIA, must be allocated in a realistic way as they bear on different age groups.

7. Revitalization of AoA: The executive of all of these options will be heavily dependent upon the effective, revitalized leadership of the specific office created by Congress to be a visible and strong advocate for older Americans--the Administration on Aging.

Our task is to confront directly this inescapable truth: we are all aging. When we talk about planning for the elderly, we are dealing with our future selves.

OPTIONS/CONCLUSIONS SUBMITTED BY THE TASK PANEL ON THE ELDERLY

OUTREACH: The problem of accessibility can be ameliorated using an outreach approach, with a coordinator integrating the various services available within the community. Continuing training at the community level of such outreach and information workers is vital and is the foundation upon which services to the elderly within their communities must be based. Such training would enable those working with the elderly to recognize needs, respond appropriately, and, most important, to regularly follow-up on the treatment plan.

HOME CARE: Older people should not have to "serve time" in an institution just because they become ill unless such care is medically necessary or it is their own personal preference.

Home care must become an essential component of the continuum of mental and physical health care of the elderly. This is in agreement with the concept expressed in S. 2009 and the Government Accounting Office (GAO) report of December 30, 1977.

Such services will do much to enhance the quality of their lives and contain the rising costs of health care.

A major concern of the panel is that in any home care program there must be a built-in circuit breaker so that at the point where home care costs near institutional costs—indicating potentially greater need than can be coped with in the home setting-a physician will be required to reevaluate the treatment plan. This step would ensure appropriate level of treatment in the home and would guard against excess usage and abuse.

MEDICARE: The discriminatory treatment of mental health services under the provisions of Medicare must be eliminated to reduce the financial barrier to mental health services. Without losing sight of the ultimate goal of removing all discriminatory language toward mental health reimbursement in the Medicare law, the panel recognizes that an acceptable short-range alternative is reduction of the beneficiary co-insurance from 50 percent to 20 percent--in line with standard Medicare coverage--and increase of the maximum allowable reimbursement for mental conditions to $750 in any calendar year.

GERIATRIC TRAINING:

(a) Each medical school which demonstrates sincere interest in incorporating training in geriatric medicine into its curriculum should receive up to $100,000 a year in support of this activity. Demonstration of interest shall be constituted by the presence on the staff or immediate availability of an appropriately trained and committed person who shall hold full academic rank and have access to the school's decision-making body.

(b) There shall be made available to 25 graduate programs in clinical psychology, 25 graduate programs in social work, and 25 graduate programs in nursing $75,000 each in support of specialized clinical training for educators and practitioners in social gerontology, meeting similar criteria as outlined for medical school eligibility.

RESEARCH - Organic Brain Diseases:

There must be a major national effort to promote and support accelerated research on the single most terrifying mental health problem of the elderly—organic brain diseases. Additional funds must be earmarked to intensify research in medical schools, hospitals, and research institutes on these dread diseases which are so costly in terms of human anguish and health care expenses. Further, the National Institute on Aging, the National Institute of Neurological and Communicative Disorders and Stroke, and the National Institute of Mental Health should be directed to conduct and support such research. This effort should be coordinated by the National Institute on Aging.

ALLOCATION OF RESEARCH RESOURCES:

The Secretary of Health, Education, and Welfare and the Office of Management and Budget should independently reexamine how existing Federal resources are being spent—with special attention to NIMH and NIA—and to increase or reallocate such resources available in research, training, and mental health services for the elderly proportionate with their current needs and the needs of the larger future populations of elderly.

ADMINISTRATION ON AGING - Revitalization:

The position of the Commission of the Administration on Aging MUST be reaffirmed to fulfill legislative intent and mandate. This will enable the Administration on Aging to be a strong and highly visible advocate for older Americans as intended by Congress.

INTRODUCTION

The graying of America is one of the most significant demographic trends of this century. Everyday, 5,000 Americans join the ranks of those over 65, while only 3,600 die--a net gain of 1,400 elderly a day (Butler 1977a). The total number of older Americans is expected to increase from 23 million today to 55 million by 2030 (U.S. Census Bureau 1977). The 75-plus age group is the fastest growing segment of the U.S. population (Butler and Lewis 1977).

Seventy-eight percent of the elderly are independent and live at home (National Center for Health Statistics (NCHS) Health Interview Survey 1975). Five percent are in institutions (Cohen 1977; NCHS National Nursing Home Survey 1973-74). Seventeen percent live in the community, but are unable to carry on major activities (NCHS Health Interview Survey 1975). This group of high-risk older people are prime users of the health care system.

Mental illness is more prevalent in the elderly than in younger adults. An estimated 15 to 25 percent of older persons have significant mental health problems (Cohen 1977). Psychosis increases after age 65, and even more so beyond age 75 (Cohen 1977). Twenty-five percent of all reported suicides in this country are committed by elderly persons (Cohen 1977). The chronic health problems that afflict 86 percent of the aged (Cohen 1977) and the financial difficulties faced by many clearly contribute to increasing stress. The stresses affecting the mental health of the elderly are not unique, but they are multiple and pervasive.

The National Institute of Mental Health's evaluation of aging programs indicates that "despite the high rates of mental disorder, treatment statistics show that the elderly receive less care than younger adults and their rate of care per 100,000 elderly population is dropping in contrast to the rising care of other adults (Socio-Technical Systems 1974)." Only 4 percent (Cohen 1977) of patients seen at public outpatient mental health clinics and 2 percent of those seen in private psychiatric care are elderly (Butler and Lewis 1977).

In addition, a growing trend in recent years has been to transfer older patients out of costly State mental hospital into less expensive broarding homes. Very often, these homes lack adequate medical, nursing, social, and psychiatric care. Residents of these facilities are not included in epidemiologic studies of the prevalence of mental disorders among the elderly, which base their conclusions on data from mental hospitals and community mental health centers. The rate of mental illness among the old, therefore, is vastly underestimated (Butler 1975). To rectify this situation, we must bring diagnosis and treatment of the old back into the mainstream of the American health care system. This will both ease the financial and emotional burdens on the families of the elderly and be cost-effective for the nation as a whole.

Given these facts, the Task Panel on the Elderly chose to concentrate on some fundamental areas where action recommended by the Commission can be implemented within existing Federal legislation or with amendments to such legislation. In some instances, amendments are already being considered in the Congress. The intent of the panel is that its recommendations will have a multiplying effect that will ultimately benefit ALL older Americans, as well as help contain the rising costs of health care for the old. The options submitted are not presented in order of priority; we believe each to be of equal weight and should be incorporated simultaneously.

The panel is aware of the myriad of specific problems which plague older people and are contributing factors in their mental health problems. We have not addressed ourselves in this report specifically to the broad issues of housing, supplemental income, minority discrimination, the handicapped, nursing homes, or retirement. The panel did not have the resources to effectively add to the work being done on these problems by other departments, agencies, committees, and private organizations. Nonetheless, we acknowledge the adverse effects of these issues on the quality of later life.

The Task Panel on the Elderly believes that practical attention given to the special problems and needs of today's older Americans ultimately will reduce the unnecessary and costly dependence of the elderly of the future.

OUTREACH - An Approach to Underserved Older Americans [1]

Since many different agencies are involved in dealing with the elderly, there is a need for a planned, integrated system of services for older people--in individual treatment programs as well as at the community level.

At present, it can be demonstrated that the elderly represent a high-risk population for emotional disorders and organic brain syndromes with manifestations of behavioral changes. It has also been demonstrated that such persons respond favorably to therapeutic intervention, but special effort is necessary to bring the patient, the family, and the therapist together (Fields 1977). Fears that the costs of treatment will be exorbitant are unfounded. Having survived into old age, the elderly are a hardy segment of our population. Even modest therapeutic steps go a long way toward resolving their mental health problems. Although treatment of the elderly may not always be "curative," our present state of knowledge permits treatment that enables them to maintain a satisfactory level of functioning and prevents further deterioration.

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[1] Outreach service is not to be confused with outpatient services. Outreach programs endeavor to locate the elderly in need of care within the community and facilitate their contact with available caregivers and agencies. Outpatient services are those direct health services which are provided on an ambulatory basis.

In spite of the potential benefits of treatment, elderly persons are not represented proportionately in the mental health care delivery system. This reflects their reluctance to ask for help, which is probably strongly influenced by societal and cultural attitudes which lead the elderly to regard themselves as being underserving. It also reflects caregivers negative attitudes and lack of interest in the elderly. It often requires a strenuous outreach effort to locate older persons who have problems and to facilitate their contact with available caregivers and agencies. Outreach is merely the beginning of the process of service to the elderly; it must be backed up by available services. At last count, there were at least 134 federally-sponsored or supported programs (Duke University Center Report on Advances in Research 1977) which provide assistance to older people. Clearly, the effectiveness of available sources can be maximized by a trained community worker able to mesh existing needs with available resources.

The elderly are especially likely to have a combination of social-psychological-physical health problems. Consequently, a multi-disciplinary therapeutic approach is essential. To facilitate full efficiency of available services, a coordinator should be designated at the community level to make certain that that the treatment plan utilizes various existing professional disciplines and community facilities.

The need for therapeutic care for the elderly can no longer be considered theoretical. The effectiveness of treatment has already been demonstrated. In one Texas county where an outreach information and referral program was put into operation, during a 4-year period (September 1973 to August 1977) there was a reduction in mean-length of stay of the over-65 patients from 111 days to 53 days. This substantial decrease in hospital stays resulted in a cost reduction of more than $1.1 million. In a control county (also in Texas) that lacked outreach efforts, the mean-length of stay during the same period was 114 days (Bryson 1977).

Given the facts that services do exist, that treatment of the elderly can be effective, that the mental health treatment statistics show the elderly receive less care than younger adults, and that the rate of care per 100,000 elderly is dropping in contrast to the rising care for other adults, the Task Panel on the Elderly concludes:

> The problem of accessibility can be ameliorated using an outreach approach, with a coordinator integrating the various services available within the community. Continuing training at the community level of such outreach and information workers is vital and is the foundation upon which service to the elderly within their communities must be based. Such training would enable those working with the elderly to recognized the needs, respond appropriately, and most important, to regularly follow-up on the treatment plan.

Implementing Agency

Each State has a unit on aging. Area and/or community agencies on aging have been mandated to dispense information and to make referrals. It is at this level that outreach personnel can function, transmitting information, making referrals to available mental and other health services, and following through. Therefore, ongoing training of workers becomes a vital element of the continuing program of effective caregiving. The panel is unanimous in its conviction that the participants in such training sessions must be the workers themselves. Training should not be limited to or be predominantly aimed at administrative level personnel.

The Administration on Aging (Title IV, Part A. Sec. 404) together with the National Institute on Mental Health's Center for Studies of the Mental Health of the Aging, can mandate area agencies to conduct training in cooperation with local departments of mental health. These two agencies can be the conduits of funds necessary for such training.

Estimated Costs

The panel estimates that a program of continuing training of outreach information and referral workers would cost: first year--$3 million; second year--$4 million; third year--$5 million.

High quality care is possible now. Individual oriented service delivery is possible now. Using existing legislation, the underserved older Americans can begin to be reached now.

HOME CARE - A component in the continuum of mental health care of the elderly.

In the last few years, public attention to the elderly has been focused on those who are in nursing homes. It is a fact that public programs support nursing home care disproportionately (Congressional Budget Office 1977); it is also a fact that this industry has been repeatedly racked with charges of abuse, neglect, and fraud (Washington Report 1977). Unfortunately, this publicity has not only reinforced the connection between old age and deterioration in the minds of many, it has also obscured the fact that the vast majority of elderly live on their own in the community. Home is extraordinarily significant to many older persons. It is part of their identity, a place where they can maintain a sense of autonomy and control. In a Nation of home owners, the idea of a personal house is deeply ingrained; 69 percent of older people own their homes (Butler 1975). In any event, institutional living is viewed by many as a loss of personal liberty and dignity.

Home can also be a euphemism. Although we recognize the importance and security of having a home, the panel does not overlook the fact that some older people dislike their living conditions, have never felt "at home" where they are, suffer from illnesses which make living at home difficult; and are eager to move somewhere else-even to an institution.

In general, the Task Panel on the Elderly believes that home care offers the best and most cost-effective treatment location except when people are physically endangered or when adequate support services or persons are not available in the home. The panel does not regard home care as a substitute for institutionalization but rather as a complementary service mode for the elderly.

Professionals in the field of aging have expressed the opinion--and provided data to support it--that an individual should be helped to remain in his or her own home for as long as possible. If this can be done, less time and money will be spent in the institution, if institutional care becomes necessary. On December 30, 1977, the Government Accounting Office issued a report (HRD 78-19) on the cost-effectiveness of home care and concludes "DHEW should develop for the Congress consideration a comprehensive national policy for delivery of home health services" (GAO Report 1977).

Further, faced with increasing health care costs, the panel agrees that we must seek alternatives which could help the patient shorten the number of days in a hospital or even be able to recover from a disabling mental and physical illness without hospitalization. Secretary Califano has stated (Congressional Record 1977) that as many as 100,000 of the 700,000 people in acute care hospitals do not need to be there and could be better cared for at home. He said that this extra cost amounted to approximately $2.6 billion a year.

A full range of home care services ought to include support services as well as health care. Support services include adult day care centers, meal preparation, personal care, shopping, transportation, and light housekeeping. They are essentially preventive measures, attempting to keep the elderly in a stable condition of health for as long as possible.

Development of home care services should be based on careful community planning for the total spectrum of health services. The older person's desire for home care should be paramount. The physicians, visiting nurses, social workers, physician's assistants, or nurse practitioners should work in concert with the older person to determine an adequate array of services.

At present, some of these services are reimbursed by the government but are fragmented and restrictive without regard to needs. On August 4, 1977, a bill was introduced (S. 2009) "to amend Title XVIII of the Social Security Act to eliminate certain restrictions and limitations imposed for receipt of home health services, to redesignate such services as 'home care service,' and otherwise to expand, improve, and make more accessible home care services to those in need thereof; and to amend Title XIX to include home services (as defined in Title XVIII) among the services which must be covered under an approved State plan for medical assistance under Title XIX" (Congressional Record 1977).

The Task Panel on the Elderly concludes that:

> Older people should not have to "serve time" in an institution just because they become ill unless such care is medically necessary or it is their own personal preference.

Home care service must become an essential component of the continuum of mental and physical health care of the elderly. This is in agreement with the concept expressed in S. 2009 and the GAO Report of December 30, 1977. Such services will do much to enhance the quality of their lives and contain the rising costs of health care.

A major concern of the panel is that in any home care program, there must be a built-in circuit breaker so that when home care costs approach institutional costs--indicating potentially greater need than can be coped with in the home setting--a physician will be required to re-evaluate the treatment plan. This step would ensure appropriate level of treatment in the home and would guard against excess usage and abuse.

Implementing Agency

Responsibility for development of such programs should be designed with the Administration on Aging, DHEW. Area agencies on aging will be responsible for the actual implementation of the program.

Estimated Costs

The panel submits the estimates for such a program made by the Congressional Budget Office (Congressional Budget Office February 1977): 1980--$0.9 to 1.6 billion; 1982--1.8 to 3.9 billion; 1985--3.2 to 11.1 billion. These figures may be compared to the 1976 costs of nursing home care in the United States of $10 billion (Cohen 1977).

MEDICARE - the need for reform

One-third of the elderly are below or hover at the poverty line (U.S. Senate Special Committee on Aging 1977). The average single older person has approximately $75 a week (Butler and Lewis 1977) on which to live. For these reasons, expansion of ambulatory mental health benefits must include a financing mechanism which enables the elderly to afford available services.

Passage of the Medicare Program (Social Security Act 1976) in 1965 was intended to alleviate much of the financial burden on the elderly seeking health care. Medicare legislation established an unfortunate precedent for discriminatory treatment of mental health care. Medicare, Part B covers reimbursement for physician services with a 20 percent co-insurance by the beneficiary and generally no maximum on the amount of reimbursement available. The legislation, however, arbitrarily increased the co-insurance rate to 5- percent and placed a maximum reimbursement limit of $250 per calendar year for physician services related to mental disorders. This arbitrary restraint ignores the fact that mental illness is often acute and the patient benefits from prompt treatment. If intervention for mental illness is not prompt, it--like physical disease--can become chronic and more difficult (and expensive) to treat.

Discriminatory financing for ambulatory mental health services provides incentives to hospitalization and general services not designed for treatment of mental disorders. Yet studies have indicated that as many as 60 or more percent of physician visits are from sufferers of emotional distress rather than organic illness (Cummings 1977). If anything, current Medicare restrictions regard inappropriate service for mental and emotional distress. NIMH's Center for Studies on the Mental Health of the Aging recently stated that "whereas the elderly are underserved at outpatient clinics, a staggering 30 percent of the public mental hospital patients are over age 65.

This is in part due to skewed Medicare coverage, where outpatient reimbursement for mental health care is severely restricted, thereby forcing a number of otherwise unnecessary hospitalizations" (Cohen 1977).

As restrictive as the original Medicare legislation was with regard to financing mental health treatment, the current situation is even worse. Since its enactment in 1965, the portion of the Medicare Act restricting mental health coverage has never been revised. Soaring inflation within the health care system has, in effect, further reduced the limited coverage originally endorsed by Congress. Since 1965, charges for psychiatric office visits have increased by 68 percent (DHEW/Health Care Financing Administration 1977). With no corresponding increases in the $250 maximum, today's elderly are reimbursed for less than half of the services they would have been able to receive a decade ago. It is noteworthy that in the same time-span, the monthly premium for Supplemental Medical Insurance (part B) has been revised eight times and more than doubled (from the original $36.00 to a current $92.40 per year) (DHEW/HCFA 1977). The premium is scheduled to be increased again in July 1978.

At present utilization rates, in 1979 an estimated 285,000 beneficiaries will use some mental health service under part B (DHEW/Social Security Administration 1977). In 1975, Medicare reimbursement for all mental health treatment (both parts A and B) was $241 million (DHEW/HCFA 1977). Part B reimbursement for mental conditions was less than 1 percent of the total SMI reimbursement; part A was approximately 2 percent of the total (DHEW/HCFA 1977).

The Task Panel on the Elderly concludes that:

> The discriminatory treatment of mental health services under the provisions of Medicare must be eliminated to reduce the financial barrier to mental health services. Without losing sight of the ultimate goal of removing all discrimnatory language toward mental health reimbursement in the Medicare law, the panel recognizes that an acceptable short--range alternative is reduction of the beneficiary co-insurance from 50 percent to 20 percent--in line with standard Medicare coverage--and increase of the maximum allowable reimbursement for mental conditions to $750 in any calendar year.

Implementing Agency

Department of Health, Education, and Welfare following amendment to the Social Security Act, Title XVIII, Section 1833. (c).

Estimated Costs

Official DHEW cost estimates for 1979 for mental health services show anticipated expenditures of $19 million under present part B restrictions and an additional $18 million cost if the co-insurance were reduced and the maximum tripled (DHEW/SSA 1977).

A 5-year cost projection for implementing this option follows (DHEW/SSA 1977). The panel feels that discriminatory language in the law must be removed within the next 5 years, as it is unlikely that a $750 maximum reimbursement in 1983 will be any more realistic than $250 is today.

	Under Present Law (in millions of dollars)	Additional to reduce co-insurance to 20% and increase maximum to $750 (in million of dollars)
1979	19	18
1980	22	22
1981	26	26
1982	31	32
1983	38	38

The panel again cautions that the additional cost to cover the short-term option is NOT discounted by the savings to be realized from anticipated lower hospitalization expenditures or the substitution for existing part B expenditures.

GERIATRIC TRAINING

Geriatric medicine encompasses the information, the people and the institutions devoted to the social, preventive, clinical, and therapeutic aspects of illness in old age.

In order to meet the needs of older people for affordable high quality physical and psychiatric care, it is imperative that the special perspective of the body of knowledge of geriatric medicine be introduced into the curricula of our medical schools; intern and residency training; programs of continuing education; schools of nursing, clinical psychology, and social work; and into the training of paraprofessionals and other health providers.

One of the arguments in favor of the inclusion of geriatric medicine in medical schools and health provider training centers is that this body of special knowledge already exists, far from complete but nonetheless substantial. The medical data base includes diseases which are peculiar to old age, common diseases which behave differently in old age, drug responses unique to old age, and the effects of interaction of the multiple pathologies found in old age. Financial support to these schools and training programs will promote dissemination of the knowledge to those who will provide care in the future.

Persons 65 and over currently constitute 11 percent of the population (U.S. Census 1976). They are heavy consumers of health services, and deserve practitioners who are trained to correctly diagnose and properly treat the illness which affects them. Fifty-six cents of every Federal health dollar went to the care and treatment of the elderly in 1977 (U.S. Budget 1979). We have every right to expect that those providing the care receive special training in caring for the elderly.

As the number of elderly and their proportion relative to the population as a whole grow in the next several generations, it will become even more imperative for substantial members of trained caregivers to be alert to and capable of dealing with the problems of the elderly. Sir Ferguson Anderson, eminent Scottish geriatrician, stated, "No one using their innate common sense can fail to realize that in every developed country the whole course of health and social services must be altered to cope with the increasing number of the very old.... This group, particularly of the 85's and over, are frequently in need of assistance. It is clearly shown that disability increases markedly with advancing age.... Methodology must be introduced which depends on any early and accurate list of diagnoses, appropriate therapy and continuity of care. More and more beds in old people's homes or in hospitals are not the fundamental solution" (Anderson 1977).

If we are to have an effective, responsible health care system, we must accurately measure the type and the proportions of the problems being encountered. Indirectly, by training care providers to properly diagnose and treat the diseases they encounter, we will be better able to collect data on the prevalence of specific diseases common to the elderly. This will improve the future training of caregivers and yield more accurate information for psychosocial and biomedical researchers.

Geriatric medicine must be incorporated systematically and comprehensively into American medical education. It is imperative that every medical student be exposed to aging in the context of normal human development and be aware that some diseases present themselves differently in the old. Many of the illness of the old can be treated or even reversed if, and only if, they are accurately and promptly diagnosed. This is especially true in the area of mental health, where there are over 100 reversible syndromes that may mimic senil dementia (Butler 1977b); yet physicians who are unfamiliar with the mental illnesses of the old may simple diagnose confusion and forgetfulnesses as symptoms of organic brain disease. The older person who could have been restored to health is instead relegated to an institution. This is costly in both financial and human terms. Geriatric medicine should be taught within the mainstream courses of the first 2 (preclinical) years of medical school. Lectures in disciplines such as pathology, micro-biology, and pharmacology should include information related to aging. In the last 2 (clinical) years, medical students should rotate through a variety of training settings, ranging from long-term care facilities to places where healthy old people congregate (such as preventive clinicals), in order to see a broad spectrum of older people, not just the sick and weak. It is noteworthy that even though on any day there are more patients in nursing home beds than in general hospital beds, not one medical school yet requires students to routinely rotate through nursing homes (Butler 1977b).

The systematic introduction of the body of knowledge of geriatric medicine into curricula and the exposure of medical students to a range of training sites would do much to alter physicians' negative attitudes toward the old. Young medical students are showing an increasing interest in learning how to care for the old. A 1976 survey conducted by the American Medical Association revealed that 75 percent of practicing physicians also feel the need for such training (Butler 1976). The physician must change from a passive custodial role to an active, enthusiastic approach founded on knowledge and experience. To treat the older patient most effectively, the physician must have the organizing ability to cooperate with nurses, social workers, voluntary societies, paramedical teams and medical colleagues. Success will ultimately depend on the physician's achievement in inspiring and motivating not only the professional staff but also the older people themselves.

Many older people expect to be unhealthly when they are old, and if they consult relatives and friends, this incorrect assumption may be confirmed. Sick old people are sick because of illness, not because of old age. Moreover, it is unusual to see an elderly ill person who cannot be helped in some way. The least they should be able to expect, once they have overcome social, financial, and travel barriers, is to visit a practitioner who is trained to treat their special needs. Therefore, the Task Panel on the Elderly concludes:

> Each medical school which demonstrates sincere interest in incorporating training in geriatric medicine into its curriculum should receive up to $100,000 a year in support of this activity. Demonstration of this interest shall be constituted by the presence on the staff or immediate availability of an appropriately trained and committed person who shall hold full academic rank and have access to the school's decision making body.

The panel also notes that the need for training in geriatric medicine has begun to be recognized within the Legislative Branch. On November 3, 1977, S. 2287 (Burdick 1977) was introduced "To amend Title VII of the Public Health Service Act to provide for making grants to medical schools to assist them in the establishment and operating of educational programs in geriatrics."

Implementing Agencies

DHEW, Health Resources Administration and/or National Institute on Aging.

Geriatric Training of clinical psychologists, social workers, and nurses:
(VandenBos 1977)

These three professions train many of the providers of a physical and mental health services to the elderly. Psychologists have been in the forefront of psychosocial research on aging, particularly behavioral research and research on mental processes, and provide direct mental health services to the elderly through psychotherapy, psychological assessment, and consultation. Social workers have an important role in helping the elderly maintain themselves in the community and in working with families of the elderly. Social workers are predominant on both the service and the administration staff of social and welfare agencies and are significant in providing services for the elderly in institutions and in the community. Nurses are critical to the 24-hour service provided the institutionalized elderly and plan a major role in aiding the elderly to overcome barriers to adequate health care through such programs as visiting nurses, through the public health system, and in the Community Mental Health movement.

Like physicians, most of the professionals from these fields do not receive a systematic introductory course about the elderly in their basic education. Instead, these professionals gain this information piecemeal through on-the-job experiences, through special divisions within their national associations, or through professional associations specializing in problems of the elderly. There is clearly a need to include both general introductory courses on gerontology and specialized instruction in social gerontology in their formal training.

In recognition of the past work and the continuing significant roles played by these professionals in the direct delivery of care to the elderly, the Task Panel on the Elderly concludes that:

> There shall be made available to 25 graduate programs in clinical psychology, 25 graduate programs in social work, and 25 graduate programs in nursing $75,000 each in support of specialized clinical training for educators and practitioners in social gerontology, meeting similar criteria as outlined for medical school eligibility.

Nothing in the previous statements shall be construed as precluding the development of multidisciplinary centers for training and research in geriatrics. Such centers combining graduate programs in a number of disciplines, including medical education, would be considered eligible for combined funding under each eligible discipline.

Implementing Agency

Department of Health, Education, and Welfare; Health Resources Administration.

Estimated Costs

Medical Schools	$100,000	(max. 114 schools)	$11,400,000
Clinical Psychology	$75,000	(max. 25 schools)	1,875,000
Nursing	$75,000	(max. 25 schools)	1,875,000
Social Work	$75,000	(max. 25 schools)	1,875,000
			$17,025,000

Physicians, psychologists, nurses, and social workers must be trained to recognize and be sensitive to the unique attributes of their older patients. The relatively small expenditure to support geriatric training in these disciplines will do much to alleviate the human and economic costs resulting from misdiagnosis and ignorance in treating the mental and physical disabilities of the elderly. We must use the lead time we have wisely in preparing for the increasing number of elderly that will have to be served by these professionals. It is far better to train these professionals now than be forced to build institutions in the future that would be reminders of our poor preparation for the demographic certainty of a changing population.

RESEARCH - Organic Brain Diseases

Few would argue with the assertion that the most feared aspect of growing old is losing one's capability to relate, physically and emotionally, to one's friends, family, and environment. Clearly, however, that is the fate of an all too significant proportion of our older citizens. In a distressing large number of older people, age-related degenerative changes in both the central and peripheral nervous systems lead to a loss of bodily and cognitive functions, which often makes expensive institutional care necessary.

Although it is true that considerable Federal presence already exists in support of studies of both normal and disordered nervous function, altogether too little attention is presently being given to the problems of the aging and the aged, even in light of the fact that various forms of nervous system impairment account for a great majority of admissions of older people to hospitals and nursing homes. Perhaps the most stark example that can be offered regarding the catastrophic nature of this process of mental decline in the elderly is that of senile dementia, the end point in which is a complete lack of awareness of the environment surrounding the individual, frequently accompanied by a loss of both voluntary and involuntary motor functions, leading to muscular uncoordination, disorientation with respect to the time and place, and failure of sphincteric function (i.e., incontinence).

Systematic research on the function of the nervous system is an extremely difficult task, requiring highly sophisticated technology and substantially more manpower than is currently devoted to it. Even more difficult, therefore, is the study of changes in nervous function as a consequence of the aging process, since the age dimension requires observation over a substantial period of time for research analysis and definition.

Despite these difficulties, the Task Panel on the Elderly unanimously agrees that the National Institutes of Health would be derelict if they did not attempt to approach the specific issues of aging as they relate to the nervous system. One requirement of the Research on Aging Act of 1974 that created the National Institute of Aging (P.L. 93-296) was the development of an HEW-wide research plan for aging. NIA as the lead agency in aging research has developed plans for descriptive and analytic research on the alterations which occur in neural function as a consequence of age.

This planned program will focus on clinical intervention in brain aging problems to minimize and ultimately prevent these disorders and their consequences. It will have the following components:

(1) A considerably greater degree of understanding must be obtained concerning the morphological changes in both central and peripheral nervous systems with age, requiring a competence in the neuroanatomical and neuropathological sciences. The techniques to be employed would include electron microscopy, autoradiography, and histochemistry and cytochemistry.

(2) Structural information is valuable only to the extent that it can be correlated with functional change. Accordingly, a second capacity would be developed simultaneously in the area of neurophysiology, requiring both basic and clinical neurological competence to interpret alterations in electrical and neuromotor activity as a consequence of aging, in both animal and human populations (Including the Baltimore Longitudinal Study on Aging Population by NIA).

(3) While it is asserted that most if not all of the detrimental changes in nervous function with age are intrinsic to the nervous system itself, it also seems possible that some proportion of these changes relates to alterations in the nutritional status of the nervous system, i.e., the supply of oxygen and other nutrients provided by the vascular system. Accordingly, a competence in the area of cerebrovascular and blood-brain barrier physiology would seem clearly appropriate to develop a knowledge base complementary to that achieved by the morphological and physiological units described previously.

(4) It is most apparent that an increased understanding of the mechanisms whereby nerve impulses are transmitted or impeded in the elderly would demand an increased competence in the areas of neurochemistry and neuropharmacology. Little significant information exists today as to the systematic changes which may occur in the aging nervous system with respect to its

responsiveness to so-called neurotransmitter substances. Selected changes in responsiveness to, or synthesis of neurotransmitter materials could account for a number of alterations in normal nerve function observed as a result of the passage of years, not from pathological degeneration.

(5) Of all brain aging problems, senile dementia of the Alzheimer's disease type stands as the most formidable to individuals and society. Research will be encouraged in the clinical, behavioral, biomedical, and social aspects of this disease. Related dementias will be studied concurrently, with the intent of improving diagnosis and treatment of reversible syndromes.

(6) Many aged commonly suffer from sleep problems which detract markedly from the quality of their lives and their capacity to function normally. These problems require--and are amenable to--clinical, biomedical, behavioral, and social investigation.

The scope of the program outlined would require close collaboration among the National Institute on Aging, the National Institute of Neurological and Communicative Disorders and Stroke, and the National Institute of Mental Health. These institutions have already begun this process of active cooperation with the joint sponsorship of a conference on senile dementia/Alzheimer's disease and related disorders. Future efforts in the neurosciences, both in intramural research conducted by government scientists and extramurally supported grant research, would require continued cooperation to maximize the use of scarce resources and to ensure a comprehensive approach to the research problems addressed.

The new knowledge obtained through research is the ultimate service and the ultimate cost container. Without new knowledge, we will just keep on doing the same things in the same ways, at every-increasing costs. We will continue to warehouse older people in nursing homes instead of preventing the conditions that brought them there.

Some people, in search of quick payoffs and instant cures, have come to mistrust the scientists' long years of step-by-step basic research. Some may consider this "test tube" research impractical, without directed goals and not tied closely enough to human health needs. In reality, research can be people-oriented and practical.

Breakthroughs in discovering the causes of the devastating brain diseases which are responsible for the majority of institutionalizations in later years, followed by effective diagnosis and prompt treatment, could reduce the nursing home population. If we released even 10 percent of admissions, we could cut institutional costs by $1 billion annually (Butler 1977a).

American industry spends 3.2 percent of its net sales on research and development (Butler 1977a). In 1977, the Federal government spent an estimated $24 billion on health services to the elderly, but only invested two-tenths of 1 percent of this amount on aging research (Butler 1977a). Therefore, the Task Panel on the Elderly concludes:

> There must be a major national effort to promote and support accelerated research on the single most terrifying mental health problem of the elderly--organic brain diseases. Additional funds must be earmarked to intensify research in medical schools, hospitals, and research institutes on these dread diseases which are so costly in terms of human anguish and health care expenses. Further, the National Institute on Aging, the National Institute of Neurological and Communicative Disorders and Stroke, and the National Institute of Mental Health should be directed to continue to conduct and support such research. This effort should be coordinated by the National Institute on Aging.

Implementing Agency

DHEW - National Institutes of Health with the National Institute on Aging as the lead agency.

Estimated Costs

First year - $5 million and 3 positions
Fifth year - $50 million and 25 positions

A well thought-out program, phased in over a 5-year period, would make the most efficient use of available resources. The panel believes that every tax dollar spent on aging research will return to us--and to our children--a thousandfold.

ALLOCATION OF RESEARCH RESOURCES

The study of aging is not just the study of decline, loss and decrement--which do indeed accompany aging--and it is not just the study of disabilities which may in part be due to social adversities. Rather, it is the study of the normal processes of development which are fundamental to life and about which we know precious little. Research leading to a greater understanding of the normal aging process and the diseases which afflict the elderly must be included in the scope of existing research programs.

> Systematic research on the normal mental and emotional development of the elderly is needed. The later stages of adult personality development and life cycle have been neglected in past investigations. Valid and reliable normative data on behavioral, mental, and emotional functioning are needed to dispel many of the myths about the elderly. Such data will increase the quality of research on dysfunctional behavior and pathological mental processes. Psychological and behavioral problems such

as alcoholism, drug abuse, suicide, sexual difficulties, and depression also need to be researched in relation to their special significance for the elderly. Specialized treatment techniques can then be developed and assessed.

In this country there has been a general upward trend of suicides over the years. In 1975, there were approximately 27,000 recorded suicide completions and an estimated 216,000 suicide attempts (Frederick 1977a). The elderly consistently account for about 25 percent of all reported suicides (primarily because of the very high incidence rates among elderly men) (Cohen 1977; Frederick 1977a). Research, prevention, and treatment studies and personnel training must be included in the Forward Plans of the National Institute of Mental Health and other health agencies. In this instance, it may not be the elderly alone who will benefit from such studies in spite of their high suicide rate. The younger age groups have shown marked increases in both committed and attempted suicides over the past two decades (as high as 200 percent increase since 1955) (Frederick 1977b).

Nutritional research should be increased. At present, scientists, physicians, and lay persons have no adequate nutritional guidelines for the elderly. This is especially disturbing since poor nutrition has been shown to cause a reversible brain syndrome that may be misdiagnosed as senile dementia. Research also needs to be done on the economic, social, and psychological factors which influence the eating habits of the elderly.

Existing evidence on the effects of age suggests that the body's capacity to defend itself against challenge declines in almost direct proportion to the age of the experimental animals. It is now necessary to undertake detailed exploration of the immune system in elderly human beings to determine whether their loss of immune competence follows the pattern observed in rodents. Investigations will also focus on whether this decline in resistance to disease can be slowed.

It is a common clinical observation that sensitivity to drugs and the degree of adverse reaction to even small doses of therapeutic drugs tend to increase with age for reasons which thus far remain unexplained. Given the fact that Americans over age 65--who comprise 11 percent of the U.S. population--use 25 percent of all medications prescribed (Besdine 1977), the need for attaining a better understanding of the reactions of older individuals to pharmacological agents is among the foremost priorities in research on aging.

The elderly use prosthetic aids to compensate for sensory and motor losses and to maintain vital processes such as cardiovascular function. The use of advanced technology that has been developed in recent years for military, astronautical, and industrial purpose should be explored for applications which will compensate for the physical losses suffered by the elderly. The National Institute on Aging should coordinate with the National Aeronautics and Space Administration to conduct animal studies and clinical trials to further explore the possible development of prosthetic aids for the aged which will reduce the need for institutional care.

Various forms of nervous system impairment account for the majority of admissions of older people to hospitals and nursing homes. Some mental disorders are actually due to other causes such as poor nutrition, pneumonia, excessive medication, and anemia, and are therefore reversible. Other disorders involve irreversible damage to the nervous system. Research on the causes, prevention, and treatment of these disorders could result in significant economic benefits to society and prevent much suffering on the part of afflicted individuals and their families.

Demographic and epidemiologic studies must be conducted routinely to improve our identification of populations in need and to enhance our ability to allocate limited resources according to need and potential benefits.

Despite demonstrated gaps in ongoing research and documented need for research training and services designed to maintain--and if necessary, improve--the mental health of the aged population, relatively little is being done. Approximately 3 percent of the total NIMH budget is set aside for research, training, and services desgined for the elderly (Butler 1975). The panel believes that this country cannot continue to pour out money for treatment of an ever-increasing number of elderly and not attempt to plan its research and prevention spending so the needs of the elderly are taken into account. Therefore, the Task Panel on the Elderly concludes that:

The Secretary of Health, Education, and Welfare and the Office of Management and Budget should independently reexamine how existing Federal resources are being spent--with special attention to NIMH and NIA--and to increase or reallocate such resources available in research, training, and mental health services for the elderly proportionate with their current needs and the needs of the larger future populations of elderly.

ADMINISTRATION ON AGING - Revitalization

"AN ACT

To provide assistance in the development of new or improved programs to help older persons through grants to the States for community planning and services and for training--through research, development, or training project grants--and to establish within the Department of Health, Education, and Welfare an operating agency to be designated as the "Administration on Aging."

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the 'Older Americans Act of 1965' (Older Americans Act 1965)."

Twelve years ago this legislation was enacted as part of "The Great Society" program. It was a small agency with a small budget. In 1967 it was placed within the Social and Rehabilitation Services (SRS) which is the "welfare" component of DHEW. This "welfare" line plus the decisions of various SRS administrators to transfer certain AoA functions and responsibilities to other units prompted Congress to take steps to reorganize the way aging programs were to be administered. In the 1973 Amendments extending and expanding the Older Americans programs, Congress provided that:

(1) "There is established in the Office of the Secretary an Administration on Aging..." By this language Congress moved AoA from SRS to the Office of the Secretary of DHEW. In reality, the Commissioner on Aging answers to the Assistant Secretary for Human Development who is part of the "Office of the Secretary."

The Senate report on S. 50, the 1973 Amendments to the Older Americans Act, noted that: "In enacting the Older Americans Act, Congress intended that AoA should act both as an advocate for the elderly in the entire Federal government and should be the principal agency for administering service programs for the aging within DHEW.

"Unfortunately, AoA's effectiveness has been diminished by its placement at a relatively low level within DHEW. Testimony before the Special Committee on Aging, as well as the proceedings of the White House Conference on Aging, reflects a widespread disillusionment with respect to its advocacy functions.

"For these reasons the (Senate) committee deems it advisable to remove AoA from SRS and place it within the Office of the Secretary."

(2) The placing of AoA within the Office of the Secretary was reinforced by language which read, "In the performance of his functions, the Commissioner shall be directly responsible to the Office of the Secretary."

(3) Section 201(a) designates AoA as "the principal agency for carrying out this Act." The House Report (92-1203) for H.R. 15657 (pocket vetoed in October 1972), a bill that was a forerunner to the 1973 Amendments, states that "Legislative history clearly demonstrates that the intent of Congress when it first passed the Older Americans Act in 1965 was to create an entity highly visible in the Department of Health, Education, and Welfare to serve as a focal point for dealing with the problems of the aged."

The Report goes on to reassert "...the Congressional mandate to the Commissioner on Aging and giving him the powers and responsibilities he needs to carry out effective programs for older people and to work on a more equal basis with other agencies which have programs of benefit to the aged."

(4) Section 201(a) also prohibits the Secretary from approving any delegation of the Commissioner's function or authority to any officer "not directly responsible to the Commissioner." Originally such delegations of authority were permitted if they were first submitted to Congress and not disapproved. In 1974, the Commissioner requested permission to delegate certain responsibilities to the DHEW Regional Directors. Congress not only disapproved of this proposed delegation, but repealed the authority under which the delegation was originally proposed. Now the Commissioner may only delegate functions to subordinates who answer to him.

(5) In 1973, section 203 was added to the Act which requires other Federal agencies to consult and cooperate with the Administration on Aging in the planning and implementation of the programs "substantially related to the purpose of" the Older Americans Act. This provision was designed to strengthen the role of AoA as the focal point of Federal programs in Aging, while seeking to reduce overlapping and encourage better coordination among various Federal agencies.

(6) Section 211 exempts the Older Americans Act from provisions of the Joint Funding Simplification Act of 1974 (P.L. 93-510).

These six areas represent the thrust of congressional efforts to give AoA a clear mandate and the authority to carry it out. The 1973, 1974, and 1975 Amendments to the Older Americans Act of 1965 were all designed to give AoA the visibility, strength, and independence needed to fulfill its tasks while insulating its jurisdiction and its institutional integrity from the administration actions of DHEW and/or Office of Management and Budget (Rust 1977).

In view of the previously mentioned history, congressional intent and mandate, and the growth of the population older Americans, and the fact that execution of options presented and accepted will require constant vigilance, the Task Panel on the Elderly concludes:

> The position of the Commissioner of the Administration on Aging MUST be affirmed to fulfill legislative intent and mandate. This will enable the Administration on Aging to be a strong and highly visible advocate for older Americans as intended by Congress.

Implementing Office:

Office of the Secretary, DHEW

CONCLUSION

None of us knows whether we have already had the best years of our lives or whether the best are yet to come. All are capable of the greatest human expressions even up to the very end of life. The ability to love, care, and feel is potentially as great--perhaps greater--in the old as it is in the young.

We were not prepared for the dramatic rise in the number of older people that occurred during the 20th century. Many of our relatively recent programs designed to improve the life of the elderly suffer now from a lack of preparation for this population shift.

Today, we know that the elderly population will increase dramatically and we must choose our future course of action. We can either continue social, economic, and health policies which reflect our negative and fearful attitudes and our self-fulfilling prophesies to scores of forgotten or "warehoused" elderly; or we can improve ourselves and our system, thus encouraging our elders to enrich their lives and our own in the process.

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REPORT

OF

THE SECRETARY'S COMMITTEE

ON

MENTAL HEALTH AND ILLNESS

OF THE ELDERLY

September, 1977

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

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Appendix C -- Public Law 94-63, July 29, 1975 -- Committee on Mental Health and Illness of the Elderly

Appendix D -- Recommendations of the 1971 White House Conference on Aging

The Secretary's Committee
on
Mental Health and Illness of the Elderly

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Mayo Medical School
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*Replaced James E. Walker, Ed.D., resigned 11/4/76

LETTER OF TRANSMITTAL

Sept. 1, 1977

Honorable Joseph A. Califano, Jr.
Secretary
Department of Health, Education, and Welfare
Washington, D.C.

Dear Mr. Secretary:

On behalf of the Committee on Mental Health and Illness of the Elderly, I am pleased to submit our report on recommendations for addressing the mental health needs of the Nation's elderly. As required by Public Law 94-63, Section 603, the Committee has endeavored to develop a set of recommendations responsive to the following concerns:

(1) the future needs for mental health facilities, manpower, research, and training to meet the mental health care needs of elderly persons,

(2) the appropriate care of elderly persons who are in mental institutions or who have been discharged from such institutions, and

(3) proposals for implementing the recommendations of the 1971 White House Conference on Aging respecting the mental health of the elderly.

We believe the recommendations presented in this report provide the basic framework for the development of informed national policy to address the mental health needs of the Nation's elderly which, if implemented as a cohesive whole, will have far-reaching effects on the well-being of our older citizens now and in the future.

Respectfully yours,
Eric Pfeiffer
Eric Pfeiffer, M.D.
Chairman

PREFACE

The Committee on Mental Health and Illness of the Elderly was established by Congressional legislation (P.L. 94-63) on July 29, 1975 for one year's duration 1/ to conduct a study and make recommendations to the Secretary of Health, Education and Welfare for submission to Congress in three areas:

(1) the future needs for mental health facilities, manpower, research, and training to meet the mental health needs of elderly persons;

(2) the appropriate care of elderly persons who are in mental institutions or who have been discharged from such institutions; and

(3) proposals for implementing the recommendations of the 1971 White House Conference on Aging respecting the mental health of the elderly.

The Committee's recommendations were to be submitted by the Secretary to two designated Congressional Committees: the Committee on Labor and Public Welfare of the Senate 2/ and the Committee on Interstate and Foreign Commerce of the House of Representatives.

The nine member Committee was to include at least one member from the fields of psychology, psychiatry, social science, social work, and nursing, with each member exceptionally qualified by training, experience, or attainments to fulfill the Committee's functions. The following individuals were selected:

Eric Pfeiffer, M.D., Chairman
The Honorable R. Robert Geake, Ph.D., Vice Chairman

Ethel D. Allen, D.O.
Mrs. Ruth I. Knee, ACSW
The Honorable James E. Rupp
Ms. Mary E. Shaughnessy, R.N.
E. Percil Stanford, Ph.D.
Wendell M. Swenson, Ph.D.
James E. Walker, Ed.D. 3/

1/ The Committee was extended an additional year by legislative amendment to P.L. 94-63, Title VI, Section 603 (P.L. 940-460, Oct. 8, 1976). The reporting date was subsequently extended to Sept. 30, 1977.

2/ Current title: Committee on Labor and Human Resources: Subcommittee on Health and Scientific Research.

3/ Resigned 11/4/76 and was replaced by Mr. Joseph Mallisham. (citizen member)

Resources to carry out the work of the Committee were provided through the collaborative support of the National Institute of Mental Health thru its Director, Bertram S. Brown, M.D., the National Institute on Aging thru its Director, Robert N. Butler, M.D., and the Administration on Aging thru the Commissioner, Arthur S. Flemming.

Following the first meeting on September 9-10, 1976, the Committee members met regularly for the next 8 months, conducting and commissioning special studies related to its charge and framing the recommendations presented in the report. In September 1976, the Committee contracted with the Gerontological Society, the major organization representing researchers in the field of aging, to have four background papers prepared by leading experts in the field: Prevention, Stanley J. Brody, J.D., M.S.W.; Services, Bennett Gurian, M.D.; Research, Lissy Jarvik, M.D., Ph.D.; and Training, James E. Birren, Ph.D. and Bruce R. Sloane, M.D. The papers represented one of several sources of information for the Committee's deliberations. A nationwide survey of organizations concerned with the issues of mental health and/or aging was conducted to gather additional expert opinion. Approximately 125 responses were received (See Appendix A).

In April 1977, a hearing was held in Washington, D.C. to present to the public a preliminary draft of the Committee's recommendations and to elicit comments that might aid in framing the final recommendations. Members of the lay public, as well as representatives of government agencies and private sector organizations concerned with the well-being and mental health of the aged, offered many valuable suggestions which have been incorporated into this report.

In presenting its recommendations, the Committee has focused upon six major areas of concern: prevention, services, training, research, minorities, and mechanisms for implementation. Although they have been separated for clarity of presentation, all six areas are interrelated and must be viewed as a whole when any new plans for implementation are considered.

The Committee members wish to thank all those who have contributed their time, talent and experience to enhancing its knowledge and facilitating production of this report. Special thanks go to Gene D. Cohen, M.D., Chief of the NIMH Center for Studies of Mental Health of the Aging, to the Center staff, to Carole B. Allan, Ph.D., Staff Director of the Committee, and to Mrs. Linda W. Smyth and Mrs. Jill A. McDonald, secretaries for the Committee, for making this report possible. Additional thanks is also extended to Mrs. Gladys Krueger, who provided important consultation to the Committee, to Mrs. Jessie Gertman, who served as the NIA liaison, to Ms. Gail Jacoby of the NIA planning staff and to Ms. Anne H. Rosenfeld, science writer who prepared the initial draft of this report.

CHAPTER I

OVERVIEW

Enhancing the lives of older Americans today and tomorrow requires many revisions in the way we now regard and respond to the aging and their needs. Nowhere is this statement more true than when speaking of the older person's long ignored mental health requirements. The challenges posed by our 23 million elderly in 1977 will become even more acute when millions more join their ranks in the years to come. By the turn of the next century, almost 31 million Americans will have passed their 65th birthday. This is but a prelude to the long term "greying of America" with our elderly anticipated to grow to 51.6 million by the year 2030. (Bureau of the Census, 1976)

Although the past two decades have brought about significant actions on behalf of many of the Nation's long ignored minority groups, including the elderly, and have witnessed the enactment of several major pieces of legislation --- Medicare, the Older Americans Act, CMHC legislation with specialized services for the elderly, and the establishment of an Administration on Aging, a National Institute on Aging, and a Federal Council on the Aging --- untold numbers of older people are essentially untouched by them, and untold more still have problems and needs to which there has been no adequate response. The mental health needs of the Nation's elderly, in particular, continue to remain largely ignored.

The mental health problems of the elderly and the Nation's lack of response are not new issues. In 1971, the U.S. Senate Special Committee on Aging published a landmark document entitled Mental Health Care and the Elderly: Shortcomings in Public Policy. The 1971 White House Conference on Aging in recognition of the magnitude of the problem set forth a set of specific recommendations to address these concerns. (See Appendix D) To this day, however, the recommendations, although still valid, have gone largely unheeded. The problems identified by the White House Conference delegates and the Senate report remain largely the same in 1977 as they were in 1971 --- only their dimensions have changed as the older population itself continues to grow.

The Need

Even a cursory glance at the situation of our Nation's older citizens reveals that, for many, growing old in America can still be an obstacle course for the human spirit. Added to the natural social and physical losses of the later years are additional burdens bred by prejudice, isolation, and societal insensitivity to the experience of aging.

Although it is true that most older persons -- despite the multiple problems and stresses characterizing their lives -- continue to maintain their emotional well-being, the magnitude of mental health problems affecting large numbers cannot be ignored. Consider the following;

- Mental illness appears to be more prevalent among the elderly than among younger adults; research findings derived from a number of community surveys indicate that 15-25% of older persons have significant symptoms of mental illness. (Lowenthal, 1976)(Cohen, 1977)

- The likelihood of psychosis, the most serious form of mental disorder increases significantly after age 65 -- even more so beyond 75, and is more than twice as common in the over 75 age group as in 25-34 year olds (Butler and Lewis, 1977; World Health Organization, 1959)

- The incidence of depression is likewise significant in persons 65 and older. When based on psychiatrists diagnoses, prevalence rates for depressive disorders in community residents 65+ are in the range of 10%. The incident of transient, but significant symptoms of depression (as distinct from depressive illness) appears to be considerably higher among the elderly than among younger members of the community. (Gurland, 1976)

- Persons age 65+ make up only 10% of our population, yet they account for 16% of the Nation's reported suicides. Nearly one out of every four suicides is committed by a person age 60 or over. (National Center for Health Statistics, 1977b)

- Senility in a severe form, affects more than one million older persons and reduces longevity by two-thirds after onset. An estimated additional two million older persons may have mild to moderate forms of this devastating disease. The prevalence of the disorder increases with advancing age. (Roth, 1976)

The statistics cited above can only approximate the dimensions of the mental health problems of the elderly. Comprehensive epidemiological data and community surveys of mental health status are noteworthy by their absence. What we do know with certainty, however, is that large numbers of the elderly experience multiple life stresses commonly leading to concomitant emotional problems. Again, with advancing age the prevalence and magnitude of the problems multiply immeasurably.

- Eighty-six percent of the elderly (more than 18 million) have chronic health problems typically multiple in nature, with at least three million being serious. (National Center for Health Statistics, 1977a) Clearly, many of these older people experience significant psychological reactions from stress caused by such losses of health.

- With advancing age mobility decreases dramatically as does the opportunity for social interaction. Approximately one out of five persons 65+ reports a limitation in mobility. At age 75+ the number increases markedly. (National Center for Health Statistics, 1977a)

- Poverty among the elderly is a frequently occurrence. With retirement, income drops by 1/2 to 2/3. (National Council on the Aging, 1976) With advancing years income is depleted further as limited assets are used up. In 1976, approximately 1 out of 7 persons 65+ lives on an income below the U.S. Census Bureau's poverty threshold. One out of every 3 older women who live alone falls into this category. (Bureau of the Census, 1976)

- Advancing age is characteristically accompanied by multiple personal losses -- loss of spouse, friends and children. Fourteen percent of men 65 and older are widowed; in the 75+ group the figure rises to one out of four. With women widowhood is the characteristic fact of life. Over one-half of all women age 65+ are widowed (54%). At age 75 and older the figure approaches a startling 70% who have lost their spouses. (Bureau of the Census, 1976)

- Isolation also causes obvious problems. Approximately one out of 7 men, and 1 out of 3 women age 65 and older lives alone; social isolation -- the lack of a viable family support system -- together with chronic illness (particularly severe brain disease with mental disorder) are the two most common factors leading to nursing home placement (Dunlop, 1976; Cohen, 1977). More than a million people over age 65 are in institutions. The risk increases with age after 65; five percent of the 65+ are in institutions; 10% of the 75+ are similarly placed; 20% of the 85+ are institutionalized. (Bureau of the Census, 1973)

The demographic implications of the above cited statistics are profound. Not only is the population 65+ growing at approximately twice the rate of the general population, the age group 75+ -- those at highest risk -- is increasing at an even faster rate. By the year 2000 persons 75+ will make up nearly 45% of the older population (Bureau of the Census, 1976).

The Inadequate Response

The preceding facts vividly describe the situation facing the Nation's elderly. The need for effective actions would seem to be compelling. Yet, the emotional needs of the Nation's older population go largely unmet, or inadequately met. Access to a full spectrum of appropriate services is limited.

- The Group for the Advancement of Psychiatry and the American Psychological Association have estimated that 80% of the elderly requiring mental health services do not have their needs met through existing resources. (Group for the Advancement of Psychiatry, 1970)

- Access to outpatient care is limited. When older persons do receive mental health services it is likely to be in an institutional setting. In contrast, most psychiatric care of younger persons is provided in outpatient settings. Although, the over-65 comprise about 10 percent of the population, with 15-25% experiencing significant mental health problems, at best only 4 percent of patients seen at public outpatient mental health clinics (including CMHC's) are 65 or older; only two percent in private clinics are in this age group. (Redick, Kramer, Taube, 1973, NIMH, 1977)

- Appropriate institutional care likewise is lacking. Despite the fact that 50-75% of nursing home patients have symptoms of mental illness, it is the exception rather than the rule that mental health services are provided. (NIMH, 1974) Obstacles and new exclusions exist for those elderly requiring care in mental hospitals as well. Although, the elderly still remain the largest client population of State and county mental hospitals - 25% of the total - they currently represent the lowest rate of new admissions, 5.3% in 1975. (NIMH Div. of Biometry, unpublished data) Active therapeutic programs remain a rarity.

- "Deinstitutionalization" of the Nation's mental hospitals has resulted for many elderly merely in the exchange of one form of institutional care for another. A 1971 NIMH study indicates that for persons 65+ discontinued from State and county mental hospital facilities, nursing homes are the most predominate place of referral -- accounting for almost 40% of all referrals in this age group (NIMH, 1971). In 1960 the majority of elderly mentally ill were cared for in mental hospitals; in the 1970s, they are to be found in the nursing homes of the Nation. For those elderly transferred from mental institutions to "the community" the provision of appropriate follow-up care is an infrequent occurrence. Data as to the eventual fate of this population are notably absent.

The net effect of the preceding statistics, in human terms, is staggering. Upwards of three million older persons requiring services receive no mental health care or inadequate care, and suffer a host of mental and emotional impairments that are potentially treatable and reversible. Others are placed in residential treatment settings simply because no other alternatives are available. The absence of an adequate number and range of alternative living arrangements has made inappropriate nursing home placement unavoidable for too many older citizens. Meanwhile, the nursing home industry grows. Nursing home expenditures reached a record of $10.7 billion in 1976. (Soc. Sec. Adm., 1977).

Despite the magnitude of the problems and the ever increasing costs resulting from lack of effective action, appropriate policies and adequate financial support are still not forthcoming.

- Less than two percent of Medicare dollars goes into mental health coverage for elderly and disabled beneficiaries. And only slightly over one-tenth of one percent of these dollars reimburse community mental health centers for both inpatient and ambulatory care. (Krueger, NIMH, 1977) The Medicaid program places emphasis on institutional care; outpatient services are limited. Title XX coverages of social support services relevant to mental health care are also most inadequate. Thus, the entitlement programs often result in unnecessary hospitalization and inappropriate care.

- Federal support for research and training relevant to addressing mental health problems of the elderly is disproportionately low for the size of the older population and the magnitude of its problems.

The problem will not go away, nor will it lessen in the ensuing years. The older population will continue to grow; the "old-old" among them at a particularly rapid rate; the need for appropriate services will likewise continue to grow. The time for effective action is now.

The Creation of the Committee on Mental Health and Illness of the Elderly

In 1971, the White House Conference on Aging surveyed the status of the Nation's elderly. One of the major areas targeted for attention and change was the mental health of the elderly. A number of major recommendations were made which, as previously cited, remain to this day, some six years later, largely unheeded or only partially fulfilled. (See Appendix D)

One recommendation, however, the creation of a Presidential Commission on Mental Illness of the Elderly, has resulted in the formation of the current one-year HEW Committee under the Chairmanship of Dr. Eric Pfeiffer, nationally and internationally known gerontologist and psychiatrist.

The Committee in its deliberations has endeavored to develop a set of recommendations which would, simply stated, achieve the goal envisioned by the delegates to the 1971 White House Conference on Aging: The establishment of a comprehensive and intergrated approach to addressing the mental health care needs of the Nation's elderly.

The Committee on Mental Health and Illness of the Elderly, by virtue of its unique charge as an advisory body to the Secretary of Health, Education, and Welfare and to Congress, has been able to review issues related to the mental health of the elderly from a unique perspective which permits more focused, yet broad-ranging study than that of agencies and organizations working on behalf of the aged in general, or those working to promote the mental health of the population at large.

From this perspective, it is obvious that we do not now have what might be termed a "comprehensive mental health care system for the elderly". Instead, what we have is a fragmented patchwork of Federal programs, agencies, funding and legislative authorities, compounded by diverse regional and local programs - public and private - that have evolved with minimal consideration of whether, en masse, they are responsive to the mental health needs of our elderly.

A sound national policy for the guidance of agencies is urgently needed to give direction to the mental health services for the elderly. As recommended in this report, this policy should include approaches for coordinating the current fragmented sources of Federal funding, for ensuring quality service, and for coordinating delivery of care to the elderly at the community level. This policy should also provide direction for coordinating the manpower training and research efforts which are appropriate components of several different programs.

Not surprisingly, several of our specific recommendations are not new. A number reiterate chronic "unfinished business": critical structural changes we have so far been unwilling or unable to make. Key among these is a broadened benefit structure for Medicare and Medicaid as an essential funding base for an effective mental health care system for the elderly.

What is new in these recommendations, however, is the fact that they have been thought through as part of a systematic approach to improve mental health care for the elderly. One recommendation is not seen being more important than another - i.e., support for training must not be traded off for support for research or expanded services. All of the recommendations are elements of a cohesive, interlocked "package".

The Committee recognized that these changes cannot occur overnight, and that planning and phasing-in must occur. The Committee has not delineated detailed action plans in the current report, however, as this was felt to be beyond the scope and time frame of its mandate. But if its recommendations can be used as a framework, then planning and progress can be more consistent and implementation more purposeful.

The Committee in its recommendations has attempted to lay the framework for a comprehensive and coordinated approach to addressing the mental health needs of the elderly. To bring its recommendations to life, two major courses of action are needed:

- Development of a national policy to meet the mental health care needs of the elderly and enactment of the required legislative and administrative actions.

- Establishment of a National Commission to oversee its implementation.

* * * *

We believe that the recommendations proposed in this report, if implemented, will have far-reaching effects on the well-being of our aged - now, and in the future. But we must start now to build the kind of forward-looking support system our elderly need and deserve. We have a difficult task ahead, because we must make up for the deficiencies of the past and correct existing flaws in our system as we try to shape it to anticipate and serve future needs. This requires both making better use of existing services, manpower, organizations, legislation, funding, and knowledge, and finding the resources to enhance, expand and supplement these in the future.

The Committee has taken a systematic look at the status of mental health care of the elderly now, and in the recent past, has identified current strengths and weaknesses in our organized responses to the mental health needs of the elderly, and has proposed a number of changes felt essential if we are to serve our elderly well. Given the magnitude of the Committee's charge, and the limited time and resources available to fulfill it, many questions remain unanswered. Nonetheless, we feel certain that the major recommendations represent the essential core of any national effort to improve the mental health of the elderly.

Although the current state of mental health care for the elderly is replete with major shortcomings, there is nevertheless room for optimism. Many of the components needed for effective mental health care of the elderly already exist, albeit in nascent form, or in scattered bits and pieces. We do not have to start from scratch, but we do need to take a fresh look at these fragments of a system to see how they might be better organized to serve older Americans.

The Committee's focus, naturally, has been on those aspects of the system that fall within Federal control and responsibility. However, the actual delivery of needed services to the elderly depends in large measure on the way local communities use the many resources available to them - public and private, city, state, regional and Federal - on behalf of their own aging and aged members. The recommendations to follow, if implemented, should make the task easier by bringing together Federal programs and plans in a more rationale and systematic form.

CHAPTER II

PREVENTION

Many of the Nation's elderly have been the victims of a self-fulfilling prophecy: we have assumed that nothing could be done to prevent, retard, and reverse the mental and physical deterioration that affects significant numbers of the older population and consequently have seen our prophecy fulfilled with dismaying regularity.

Yet, numerous innovative and experimental programs have demonstrated that a combination of early detection of mental health problems and appropriate treatment can do much to minimize their debilitating effects, and prevent or delay more serious illnesses from developing. We also know enough about the factors needed to sustain mental health to develop effective policy and actions geared toward achieving this objective.

The human and financial costs resulting from a health care system which ignores its preventive potential has become staggering. In 1976, nursing home costs in the U.S. rose to an astonishing 10.7 billion dollars. It is evident to this Committee that if a national policy of systematic preventive services in the area of mental health of the elderly were enacted, the extent of mental illness in the older population could be sharply reduced as would the costs stemming from our current unresponsive system of care.

Any recitation of the degree of mental illness among the older population must be counterbalanced by the statement that the overwhelming majority of older persons -- 75-85% -- continue to maintain their psychological well-being despite the multi-faceted problems often faced. An effective system of preventive care could assure that even greater numbers are able to do so in the future. Creating an effective preventive mental health system has several goals: a) preserving the good physical and mental health of those who are well; b) keeping the mildly ill from becoming more severely ill; and, c) trying to keep the severely ill from a deepening or lengthening of illness. Or, put another way, it means trying to preserve all of the elderly at their best possible level of functioning.

In order to accomplish these goals the Committee calls for the implementation of the following recommendations:

Recommendation I: Effective systems for teaching the elderly to cope with the aging process must be developed. Expanded support should be given to exploring and applying effective strategies for disseminating this knowledge through the media, education institutions, health care providers, senior citizen groups, and other community organizations.

Discussion: Central to the maintenance, protection and improvement of the physical and mental health of the older population is the enhancement of the individual's own capacity to cope with the aging process and to understand the factors which can enhance -- or inhibit -- the quality of one's own life. Thus, improving the quality of health among the older population involves not only essential changes in the current health care system --- the cornerstone of effective, preventive health rests with actions of the individual himself.

There is widespread evidence that many elderly persons do not understand the nature of the normal aging process not how to sustain and improve their physical and mental health through various preventive measures. There is a vital need to develop an increased awareness of the relationship to health and well-being of such variables as diet, exercise, social participation, as well as the appropriate utilization of medications, and the selection of proper health and social services. Many older persons are further unaware of their existing rights and entitlements under many currently existing programs designed to help them.

Overcoming these gaps in public knowledge will require an intensive public education campaign addressed not only to those who are now old, but to those who will join their ranks in the years to come. Considerable evidence exists, however, that the benefits to be derived from such a system of public education will be substantial --- the improved mental and physical well-being of many elderly persons, a lesser dependence on utilization of the formal health, mental health and social service systems and an improved capacity for sustained independent living.

Many educational routes and techniques should be used, with the mass media, and particularly television, a major focal point. Senior citizen organizations, social service agencies, church groups, and physician offices can provide particularly valuable outlets for reaching large numbers of individuals.

A collaborative effort of a number of organizations is required and different program models will need to be developed. Community mental health centers should work in close conjunction with educational, social service and senior citizen organizations in the planning and development of such programs to reach a maximum number of older persons in the country.

An additional target audience of these programs should be the families of older persons who, through a better understanding of the aging process, can participate more actively in maintaining the health and independent living of their elderly relative.

Particular attention should be directed to ethnic factors which strongly influence health attitudes, and to the development of public education programs expressly suited - stylistically and linguistically - to minority group members.

Recommendation II: Programs that provide the elderly with the opportunity for new and/or continued community roles and activities should receive increased emphasis and support.

Discussion: Retirement, especially involuntary, frequently results in loss of self-esteem, withdrawal, depression, and illness. It also often results in a severe drop in income, bringing with it a host of other concomitant problems. It has been estimated that upon retirement, income drops by 1/2 to 2/3 for the average older American. (National Council on the Aging, 1976)

In 1976, only 1 out of every 5 males 65 and over was actively employed in the labor force, a sharp contrast to the situation that existed even as recently as 15 years ago, when one of three men 65+ continued to work. (Bureau of the Census, 1976) For many, this decision to "retire" was no means by choice. Recent studies indicate that upwards of 40% of older persons did not retire voluntarily and a substantial number (1/3) would choose to continue to work if given the opportunity to do so. (National Council on the Aging, 1975)

National policy needs to be speedily enacted to provide expanded options regarding retirement so that continued participation in the work force is possible, depending on the individial's health and personal desires. More attention needs to be directed toward the development of flexible retirement policies and second careers for older persons.

Greater opportunity for volunteer service should be available for those elderly able and interested in this type of activity. Expansion of volunteer service programs such as RSVP, Senior Companions and Foster Grandparents, and the development of other new programs that use the wisdom and skills of older people are crucial to encourage continued active involvement by older people in community life. Such programs have an additional benefit: that of bringing younger community members in contact with vigorous, socially constructive older persons which may help break down negative stereotypes of aging.

Increased opportunities are also needed to permit able older people to continue their education or to share their knowledge as teachers. While many colleges, universities, and community schools have programs available to older persons, greater attention is needed to overcoming various obstacles - including transportation barriers - that limit their participation.

For those older persons who seek expanded outlets for social and intellectual exchange with their peers, there should be ample opportunity to meet others who share their interests. Senior citizen centers serve an important function as a focal point for socialization for many older individuals, but other models should be explored and encouraged as well, especially approaches that permit older people to socialize in less structured settings.

Innovative approaches should also be sought to engage the institutionalized elderly in meaningful social, volunteer, and educational activities that sustain their community contacts and their sense of self-worth.

Recommendation III: Increased support should be given to the development, dissemination, and expansion of effective models of preretirement and postretirement education programs, in cooperation with industry, unions, colleges, universities, and senior citizen and voluntary organizations.

Discussion: The transition between the roles of worker and retiree can be quite stressful, particularly for those who are financially and psychologically unprepared. While preretirement programs have been instituted by a number of organizations, most of these programs focus only, or primarily, on financial aspects of retirement with minimal attention to other important concerns of the retirement years.

Most significant is the fact that vast numbers of older persons are not reached at all by existing programs, particularly those who work in small businesses or who are self-employed. Post retirement programs, despite their demonstrated usefulness, are notably absent.

Pre- and post retirement education and/or counseling programs, to be maximally useful, must become more widely available and must be much more broadly based. They should provide true counseling and planning services geared to the needs and concerns of the retirment years; the need for regular health supervision to ensure early diagnosis and treatment should be stressed.

More systematic study is needed to determine how the form and content of such programs can most effectively be used to foster mental and physical health in the months and years following retirement, and effective models should be widely disseminated. Successful models or preretirement programs should be developed which are geared to different employer situations in both the public and private sector. Particular attention should be given to developing models to reach those who do not currently have access to existing programs.

The cost of developing such programs in the case of large businesses and government should be assumed by the organization itself. However, making such counseling more accessible to workers who are self-employed or those retiring from small organizations and businesses will require the establishment of community-based counseling programs. Federal funds should be made available to community organizations and educational institutions to provide such counseling at no, or modest, cost for local workers about to retire and in the early post retirement years.

Recommendation IV: A major program of public education should be developed to combat prejudice toward the old and to improve the image of the aging experience in the eyes of the general public; the media, service providers and the elderly themselves. Actions to combat age discrimination in all its aspects should be vigorously pursued.

Discussion: Prejudice toward older Americans pervades the fabric of our society, breeding avoidance of the old, stigmatization, isolation, and discrimination. It is found not only among the young, but among the aged themselves. The results of recent national surveys and research investigations vividly demonstrate the continuing pervasiveness of this phenomenon. (NCOA, 1975) Despite scientific evidence to the contrary, the stereotypes of old age and the negative social attitudes persist.

Ageism, like racism, thrives on myths and prejudices which are deeply entrenched; its ill effects are manifested daily in a variety of forms, both subtle and overt --- from discrimination against the elderly in employment, housing and social services of various kinds, to barriers against their continuing participation in active community roles, to the stereotyped images found in the media and advertising characterizations. It is reflected as well in the attitudes and actions of many professionals, who avoid working in geriatric settings and specialities, in part because of the mistaken notion that "old people cannot be helped" or that "it's too late to try".

As the factors contributing to ageism are complex and deep-rooted, overcoming this prejudice toward the old will undoubtedly require many years of concerted action by both the public and private sectors alike. A national commitment to this end is required which is multiple in scope, including: the development of a major public education effort involving the media, educational institutions and senior citizen organizations to provide more realistic images of aging; the expanded support of curriculum development on human aging for inclusion at all levels of the educational spectrum, from primary to professional school training, and the expanded support of programs and activities which permit older persons to remain active and involved, especially those which bring young and old together (See Recommendation II).

A continuing review of public policy and existing legislation contributing to age discrimination in all its aspects is urged. The forthcoming report of the U.S. Commission on Civil Rights Age Discrimination Study should be considered with due priority. Actions to eliminate age discrimination in federally assisted programs and activities should be vigorously pursued.

It should be obvious that the preceding set of four recommendations have been directed primarily toward preserving the good physical and mental health of the elderly who basically function well. The following recommendations address the issues and actions required to: 1) keep the vulnerable elderly and those who are mildly disabled from becoming more seriously ill; and, 2) trying to keep those who are severely ill from a deepening or lengthening of illness.

Recommendation V: To help provide appropriate services and avoid unwarranted institutionalization, a nationwide system of Comprehensive Geriatric Assessment Units should created within existing community programs to serve as assessment, assignment, treatment, and coordinating centers on an areawide basis.

Discussion: A cornerstone of any comprehensive health care program is adequate diagnosis, screening, and referral. Since health, mental health, and social-environmental problems often occur concurrently in the aged, each community should have a resource dedicated to determining accurately the needs of older persons in all three dimensions of living, and ensuring that a well-coordinated program is developed to meet them on a long-term basis. Comprehensive Geriatric Assessment Units (CGAU's) can serve these and many other essential functions.

Few such assessment centers now exist, and even fewer fulfill the comprehensive role outlined here. However, a number of local experimental programs have demonstrated their value in assuring accurate diagnosis and appropriate service delivery to the aged, (U.S. Senate, 1978); they can prove to be of particular value in reducing the admission of older mentally ill individuals to State mental hospitals and nursing homes. Although exact figures are difficult to determine, all available evidence indicates that the number of individuals who are inappropriately placed in long-term care facilities is considerable. A recent HEW report states that from a medical standpoint, 14-25% of the patients in nursing homes need not be there. (U.S. Dept. HEW, 1975). Other surveys set the figure even higher. (Dunlop, 1976)

Although few Comprehensive Geriatric Assessment Units currently exist, their establishment can be accomplished in most communities with the use of existing personnel and facilities. Existing service entities should be utilized to the maximum extent possible to minimize cost and avoid further service fragmentation. Comprehensive Geriatric Assessment Units could be housed in many types of community facilities, including general hospitals, community mental health centers, senior citizen centers, or community health centers. The exact administrative location will depend upon local community circumstances and resources.

Among the functions to be performed would be the following: 1) determining the level of appropriate care, and the services required; 2) providing expert consultation and back-up to the office-, hospital-, and institution-based physicians faced with difficult questions of diagnosis of the presumed mentally ill elderly; 3) counseling of the elderly and family members; 4) coordinating multi-disciplinary services to the elderly; and, 5) monitoring the progress and changing care needs of elderly individuals.

Although the CGAU's could be located in a variety of settings, certain criteria should be assured: 1) they should be staffed and organized to use the combined expertise of multi-disciplinary teams whose geriatric knowledge and skill spans psychiatry, psychology, medicine, social work and nursing; 2) they should be accessible to the population served; and, 3) the elderly person should be involved in planning for his own care to the maximum extent that his physical and mental condition permits.

To ensure continuity of care, Comprehensive Geriatric Assessment Units should be dedicated to the case management approach. That is, an effort should be made not only to identify the service needs of given individuals, but to see that they are met. Such Units, if required and empowered to do so, would serve in an important role in monitoring the level and continuity of services to individuals requiring long-term care.

Comprehensive Geriatric Assessment Units could be funded through a variety of sources, including health insurance or individual payment. However, it is the Committee's view that vulnerable elderly must be assured of access to these services through full coverage of these benefits (See Recommendation VIII).

Recommendation VI: Crisis intervention programs at the community level should be developed and expanded to provide services for the elderly who are at high risk of developing mental illness.

Discussion: A prime characteristic of later life is the frequent occurrence of multiple crises and stress. The relatively young usually encounter extraordinary crises such as major illness and interpersonal losses as isolated incidents. As people age, however, stress-producing situations such as bereavement, loss of employment, loss of income and loss of health are likely to occur abruptly and often in rapid succession.

Such stress-producing events often form the starting point for the onset or worsening of physical and/or mental illness. As with younger persons, however, the presence of sympathetic and supportive individuals and timely intervention during a crisis can prevent severe emotional and physical problems from developing or worsening.

The preventive potential of crisis intervention programs is indeed substantial, as evidenced by the effectiveness of a number of models that currently exist. Current efforts, however, are scattered and in no measure approximate the need. Where services do exist, their availability is often unknown. Characteristically, those who are most in need, the isolated and those who live alone, are least likely to be reached.

The development, replication and expansion of successful crisis intervention programs along with active outreach efforts is required. Our older citizens should have readily available to them individuals who understand and can respond to their emotional needs at times of particular stress, such as the loss of a spouse, involuntary retirement, criminal victimization, and the sudden onset of disabling conditions due to accidents or disease.

Community resources should include not only mental health personnel serving in crisis intervention centers, but also trained individuals likely to come in contact with the elderly during times of crisis, such as clergymen, policemen, and ambulance drivers, as well as the personnel of housing developments, senior citizen centers and outreach programs for the elderly. Sponsoring organizations for crisis intervention programs - including telephone "hot-lines", "widow-to-widow" programs, and the like - could include community mental health centers, senior citizens centers, area agencies on aging, church groups, and other voluntary organziations.

Recommendation VII: A comprehensive, long-term social support system should be developed in each community for elderly persons who are chronically ill, socially isolated, and/or frail which can provide, on a sustained basis, those services needed to promote and maintain maximum levels of functioning. Existing agencies and organizations should be used to the fullest extent possible, while new models must be designed and tested to ensure that present gaps in services are closed.

Discussion: The mental health and well-being of older persons depends in part on the kinds of emotional and functional support available from others - whether family, friends, or representatives of community organizations. Oftentimes, the existence and appropriate deployment of social support personnel and services can spell the difference between an older person who can remain as a community resident and one who requires institutionalization. (Congressional Budget Office, 1977; U.S. General Accounting Office, 1977) Ironically and tragically, however, the elderly suffering from serious mental and physical disability are often the very ones who are most deficient in supports of any nature, whether formal or informal.

Most communities have a wide variety of social services available to their residents, many of which are specifically earmarked for the elderly. But rarely are these organized into a coherent whole and used systematically in conjunction with health and other care systems to meet the specific needs of individual older persons. Individual organizations and agencies - both public and private - serve specialized clientele and rarely attempt to survey whether and how their combined efforts reach those in need of service. Even rarer is the assumption of responsibiility by some community organization for the long-term well-being of identified community elderly, particularly those known to be vulnerable.

Orchestrating a variety of existing services for elderly community residents - using the resources of local, regional, State and Federal programs, as well as voluntary organizations and agencies - requires the assuming of responsibility by a designated community organization to ensure that this occurs. The needs and resources of individual communities will dictate the nature of the management system and the spectrum of services required. Continuity of care, periodic assessment and review, and appropriate monitoring procedures must be ensured, however.

Pilot programs have demonstrated the value, feasibility, and preventive potential of such a system. It is, therefore, recommended that Federal funds should be provided to stimulate the systematic design, development, and evaluation of comprehensive social support systems geared to the specific needs of individual communities.

Recommendation VIII: The most vulnerable groups of the community dwelling elderly should be entitled to special assistance in planning for and access to the services they need: the deinstitutionalized chronically mentally ill and those with severely reduced physical and emotional capacities due to extreme old age. Federal support should be given to developing and testing models for sustained community agency responsibility for regularly monitoring and assuring needed services for these high-risk elderly.

Discussion: Two subgroups of the elderly, the chronically mentally ill who have been "deinstitutionalized" and the frail elderly, defined as persons of extreme old age with reduced physical and mental capacities, are in need of specialized long-term personalized attention and advocacy.

Accurate assessment of the overall functional status of these individuals is particularly crucial to the provision of appropriate care and avoidance of unwarranted institutionalization. At the very least, both groups should receive as an entitlement an annual evaluation of their overall functional status so that appropriate mental health and social support services can be implemented. The Comprehensive Geriatric Assessment Units described in Recommendation V, could be assigned responsibility for carrying out this essential function.

As the vulnerable elderly are often those who are most out of contact with the existing system, vigorous efforts will need to be initiated. The Comprehensive Geriatric Assessment Units should draw upon a wide spectrum of community organizations serving the elderly -- and manpower should be specifically trained -- to accomplish this end.

CHAPTER III

SERVICES

Given the fact that at least 15 percent of America's 23,000,000 elderly suffer from significant emotional and/or mental disorders, a national policy needs to be developed to provide a system of mental health services specifically geared to this population. The elderly mentally ill require a full range of mental health services to which they can have ready access. What exists currently, however, are only isolated and fragmented pieces of such a system. Even where services are available, access to these services is hampered by such obstacles as limited reimbursements (Titles XVIII and XIX of the Social Security Act) and inadequacies in current funding mechanisms (Title XX, and the Health Revenue Sharing Act, as it relates to community mental health centers).

Underlying the subsequent specific recommendations are three critical principles which relate to the characteristics of the population under consideration:

1. The health and mental health care needs of older persons are interdependent and, thus, the mental health needs of the elderly are best served when they are addressed as part of their basic health care requirements.

2. Elderly persons are responsive to appropriate treatment services geared to individual need. The variability of the health care requirements of the older population -- and the changing needs of the individual over time -- requires that a full range of mental health services, from ambulatory to full inpatient hospital care, be readily available.

3. Effective linkages are essential between social support services and general health and mental health delivery systems in order to respond to the interrelated nature of the older person's needs.

All the above cited principles need to be incorporated in a national policy aimed at ensuring comprehensiveness and continuity of care for mentally ill elderly persons. One of the glaring outcomes of the absence of such a policy has been the plight of the "deinstitutionalized" elderly, where the failure to address comprehensiveness has resulted in the failure to develop sufficient alternatives to institutionalization. Relatedly, the failure to provide continuity of care has resulted in dramatic and all too frequent failures in the transition from institution to community care. (NIMH, 1976b)

In order to operationalize the above principles, the Committee makes the following specific recommendations.

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Recommendation I: In order to improve the availability and accessibility of mental health care for elderly persons, coverage for mental health services must be provided on an equal basis with coverage for physical health care services, for both acute and chronic illnesses. In existing third-party payment programs, current inequities in coverage for mental health care services must be redressed, making mental health care services as accessible as physical health care services, for both acute and chronic illnesses.

Discussion: Although Medicare and Medicaid have made some types of health care more accessible for many elderly persons, the benefits have underemphasized mental health care for both acute and chronic mental conditions. Furthermore, Medicare and Medicaid benefits for all types of health and mental health services stress inpatient care, while providing only exceedingly limited coverage for continuing treatment and rehabilitation services on an ambulatory basis. Existing policies in Medicare specifically, have tended to foster inpatient psychiatric treatment without adequate support for outpatient, day care, or ongoing rehabilitative services. (Morris Associates, 1975; Krueger, 1977)

Current limitations on Medicare-Medicaid benefits for mental health care - both regarding the extent and types of coverage - have proven to be shortsighted, inequitable, and costly. Inpatient health and mental health services are often used when outpatient mental health care would be more appropriate and less expensive. Long-term care in nursing homes is often required for older persons who could, with access to outpatient preventive and rehabilitative services, remain outside of institutions. The availability of ambulatory or day care based mental health services has the potential for reversing developing disabilities and keeping them from becoming permanent. Yet unless there is an adequate source of funding for these services, their potential will remain unfulfilled.

A Medicare-Medicaid program providing for equal coverage for mental health services, combined with careful utilization review to ensure appropriate use of services, could contribute significantly to the creation of a more effective health care system for older Americans. The savings reaped by lessened use of costly short- and long-term inpatient services may well offset - in part or in full - those of expanded outpatient services. The most significant benefit, however, would be to ensure that older Americans receive health care in the form most appropriate to their needs, and at a time when it can most effectively ensure their best level of physical and mental functioning.

Recommendation II: A national policy to ensure the availability of a full range of mental health services for the elderly, ranging from ambulatory to home health, congregate living, day and/or night care, transitional care (halfway houses), foster homes, rehabilitative services, and specialized inpatient services, needs to be developed.

Discussion: Older patients entering the health care system do so manifesting different degrees and types of illnesses which dictate differing levels and types of care. Following systematic evaluation, such persons should be provided that level and type of care specifically suited to their needs. Additionally, as improvements result, changes in level of care should be effected with the aim of permitting the older individual to function at the highest level of independent living commensurate with his or her mental or emotional capabilities.

Currently, few communities offer the full range of mental health services, treatment and preventive facilities required to achieve the above cited objectives. Fewer still have such facilities or services available in sufficient number and accessibility to adequately address the community's needs. The availability of a full range of services gives elderly patients their best opportunity for reversing existing mental disorders and for preventing treatable diseases from becoming permanent disabilities. Only when a comprehensive care system is available can the most cost-effective level of services be utilized. In turn, the absence of such services is a major factor leading to inappropriate institutionalization. As previously cited, it has been estimated that upwards of 25% of current nursing home patients would not need to be there if alternative methods of community care were available.

In order that each elderly individual be ensured access to appropriate mental health care and unwarranted institutional placement be avoided, the Federal Government must initiate a major national effort to develop alternatives to institutional care and comprehensive mental health services to the elderly in communities throughout the Nation.

Recommendation III: In order to provide quality mental health service to the elderly, staff of health and mental health facilities providing specialized services to the elderly must have specific expertise and training in geriatric mental health care. Regulations governing third-party payments to such facilities as community mental health centers or other comprehensive mental health programs, public or private mental hospitals, or university-operated or affiliated teaching hospitals should require that these institutions demonstrate adequate staff training as a condition of provider eligibility.

Discussion: To improve the quality and quantity of mental health services available to the elderly, many general and comprehensive mental health

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facilities will have to develop special programs for the aged. P.L. 94-63 has already required this of community mental health centers; other mental health programs and services are likely to be encouraged to follow suit. However, the creation of new programs such as these requires the presence of well-trained personnel who are responsive to the special needs, characteristics, and mental health problems of older persons.

The lack of such trained personnel is currently a major barrier to providing quality care to the elderly. One approach to ensuring that staffing will be adequate is through the provider eligibility standards for third-party payment -- that is, by demanding that institutions receiving Medicare and Medicaid payments demonstrate that they offer adequate staff training for the services offered to the elderly. While current Federal regulations for hospital, skilled nursing, and intermediate care providers do require a plan for inservice training or staff development, the quality and extent of training necessary for compliance is ill-defined, and usually under funded. More precise specification is required. Further, as suggested in the following recommendation, greater support for such training should come from third-party sources.

Recommendation IV: Staff development and inservice training costs should be an allowable item for Medicare and Medicaid reimbursement up to five percent of total service delivery costs.

Discussion: Many service providers are eager to enhance their service capability to the elderly by improving the skills of their staffs. However, while recognizing a need for staff training, most health facilities, especially mental health facilities, characteristically have few financial resources available to pay for training programs for their personnel. Although some support for the costs of staff development is available through Medicare and Medicaid, these sources have been inadequately promoted and utilized for inservice training. If third-party payments can be used more extensively to enhance the capacity of mental health personnel to serve the elderly, we may see an appreciable rise in the quality of mental health care for the elderly.

The Committee, therefore, recommends that staff training costs be an allowable item of reimbursement up to five percent of total service delivery costs under current third-party payment systems.

Recommendation V: In long-term care facilities, mental health services should be regularly provided to all patients having significant mental disorders, either directly by the facility or by an outside agency by written agreement.

Discussion: Mental illness and disability are widespread among elderly residents of long-term care institutions. The best estimates agree that upwards of 50 percent show signs of significant mental impairment. (NIMH, 1974) Yet, few receive any mental health services, in part because such services are not specifically required under existing regulations, and also because funds are not generally available to pay for them. As a result, many older institutionalized individuals remain or become more disturbed and/or functionally impaired than would be the case if such services were available within such facilities.

Medicare and Medicaid regulations should therefore be redrawn to require specifically that individual mental health services be made available to such patients on a regular basis in intermediate and skilled nursing facilities, provided either by trained facility staff or on a contractual basis through such facilities as community mental health centers.

Recommendation VI: A focal point should be designated at the State level to ensure that the mental health needs of the elderly are being and will be met through careful assessment, coordination, and planning of state-wide health, mental health and social services. Financial and technical assistance should be provided to States to strengthen their capacity for geriatric mental health service assessment, coordination, planning and development.

Discussion: Effective planning, coordination and management at the State (as well as local) level is crucial to the delivery of mental health services to the elderly. At the present time, however, our service system is fragmented with no specific agency designated the responsibility nationwide to ensure that mental health services to the elderly are available and well coordinated with their other service needs.

While P.L. 94-63 mandates the creation of specialized service programs for mentally ill elderly in community mental health centers, resources available for CMHC's presently do not ensure the uniform implementation of this mandate.

As already indicated, the elderly receive less than 4% of all outpatient mental health services, despite the fact that recent surveys indicate that approximately 15% of the population 65+ suffer from significant mental health problems. The mental health needs of the elderly are clearly not being addressed. For this reason a focal point should be designated at the State level to ensure that the mental health needs of the elderly are being met and, if they are not, that appropriate services are organized. State planning agencies will need to assess State resources, the availability of Federal resources, and reimbursement mechanisms as well as local provider organizations to ensure that within the State planning area such services are developed and implemented.

CHAPTER IV

RESEARCH

Today's mental health services for the aged could be vastly improved if existing knowledge concerning mental health and illness in the elderly were more widely disseminated to practitioners and applied through direct service contact. However, even the best trained and informed mental health professsional currently confronts many clinical problems for which few satisfactory solutions can now be found, due to limitations in our current state of scientific knowledge. Senile dementia in its most severe form, for example, a disease which affects more than one million elderly persons, remains largely an enigma. It is an enigma, however, which researchers believe can someday be solved provided this Nation is willing to make a "master" commitment in terms of allocating sufficient resources for scientific investigation and the development of well trained manpower. Yet, despite the number of persons involved and the demographic trends that indicate this number will grow, no such financial commitment has yet been made. The effects of this inaction in terms of human suffering hardly needs elaboration. In terms of cost to society one need only reflect upon the ever increasing costs of nursing home care.

We believe that many of the mental health problems that now incapacitate and debilitate many of our elderly should not, and need not, be regarded as an inevitable part of growing older, or passively accepted with philosophical resignation. Rather, they represent potentially preventable, treatable , and possibly reversible dysfunctions and diseases that are facilitated by biological aging, but by no means an inevitable component.

The presence of large numbers of mentally healthy and alert individuals who sustain their intellectual and emotional integrity well into advance old age - indeed, the vast majority - attests to the fact that mental illness in the aged is just that - illness - and not the necessary price of living long.

The Committee recommends that the Federal Government spearhead a major research campaign addressed to the specific research areas defined in the pages that follow. If implemented, this program may enable an even greater proportion of the elderly to enjoy good health and sustain their mental and emotional capacities in the years to come.

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Recommendation I: An expanded national research program on the causes, treatment and prevention of senile dementia and on changes in intellectual functioning and/or ability in later life should be supported.

Discussion: At the forefront of any new research effort should be a focus on a specific cluster of mild to severe mental problems that have proven to be particularly costly for our Nation, both in economic and human terms. To the layman they are collectively known - and feared - as "senility". To clinicians and researchers there are at least three major problems and processes to be distinguished and studied more intensively: a) the memory loss and confusion resulting from irreversible brain cell damage, known as "Alzheimer's disease" or "senile dementia"; b) similar symptoms that arise from temporary and reversible brain injury and impairment, known as "reversible"(or acute) organic brain syndrome; and c) the mild losses in mental agility and ability - particularly response speed - that may accompany normal aging.

Senile dementia: The first of these, senile dementia/Alzheimer's disease (it remains to be answered by research whether this represents one or more diseases), demands particularly intensive study, because of the estimated three million Americans who suffer from this disease, with about one million afflicted with the severe form that often necessitates institutionalization. Senile dementia afflicts more than 50% of nursing home residents and probably accounts for a sizable number of nursing home admissions, although physical health problems are commonly listed as the primary diagnosis. (NIMH, 1974)

At present we cannot prevent this disease, nor can we reverse it, though intervention can result in some alleviation of accompanying suffering. Considerable evidence exists, however, to suggest that the situation need not be so hopeless in the future. Promising research leads exist, and in terms of scientific technology the point has now been reached at which major breakthrough may be possible. The development of computerized radiology (CAT Scan), for example, now makes it feasible to investigate the relationship between brain changes, mental functioning and symptoms of senile dementia. (Jarvik, 1977)

Recent research evidence suggests that this condition, once thought to be a natural concomitant of aging, now appears to be a disease to which some older persons are particularly prone, especially late in life. It may well be identical with a similar disease (Alzheimer's) that affects younger persons. According to some researchers, a "slow" virus may be the responsible agent; other investigators are pursuing other promising leads, e.g., an auto-immune dysfunction.

If we can isolate the cause or causes of Alzheimer's disease/senile dementia, we may be able to prevent permanent brain cell damage and the often severely impaired behavior that results. The potential benefits of such a break-through are appreciable; the preservation of vigorous minds in millions of older persons, and the maintenance of their capacity for independence and self care. If we can prevent Alzheimer's disease/senile dementia, fewer elderly people will require costly institutionalization or the countless hours of care and supervision by family members and community agencies.

Acute Organic Brain Syndrome: Investigations into the causes, prevention, and treatment of dementia should also be addressed to its reversible form: acute organic brain syndrome. It has been estimated that among patients diagnosed as suffering from organic brain syndrome some 10-15% are affected by its reversible form. (Butler, 1977)

Older people can develop severely disturbed and confused behavior in conjunction with diabetes and heart disease, as a reaction to many types of medication, and as a reaction to severe physical and mental stress. If the condition is properly diagnosed and treated, these mental symptoms may completely disappear. If not, they may develop into irreversible illness. Early diagnosis and intervention is of prime importance.

Although many of the causes of acute organic brain syndrome have been identified, there are undoubtedly many others now masquerading as senile dementia. Intensive research study is needed to understand better how the brains of older persons react to a variety of physiological stimuli, so that we can better recognize and treat temporarily altered brain function, and return our seemingly "senile" elders to normal functioning.

Declining Mental Vigor: Related to the preceding studies of pathological changes in mental ability should be investigations of the nature, extent and causation of changes in normal intellectual functions which may accompany the aging process. Why do brain cells die? What can be done to slow or avert the phenomenon? Why are certain intellectual functions affected while others remain relatively intact? What are the critical factors accounting for individual differences? What is the role of stress in precipitating intellectual decline as well as the role of continued activity in maintaining vigor?

The need for an increased research effort directed toward a better understanding of the normal aging process is dictated by a number of factors: the number of individuals involved, the fears of the older person himself that a decline in mental vigor is a precursor to senile dementia, and the obvious benefits to the individual, his family and society at large which would result from answers to the questions posed. Such studies, of extreme value in their own right, can also help us to understand the boundaries between mental health and illness among the aging and aged.

Recommendation II: Research on Depression: An expanded research effort to determine the causes, treatment and prevention of depression in older persons, including investigations of the relationships of depression to suicide, alcoholism and other symptomatic and behavioral disorders should be initiated.

Discussion: Depression is one of the most widespread and often unrecognized mental health problems of older people. Although prevalence rates are somewhat inexact, studies based on psychiatric data indicate that at least 1 out of 10 older persons residing in the community suffers from serious depression. While it is true that depression in community residents as diagnosed by psychiatrists is more common below age 65, depressive symptoms, as opposed to diagnosed depressive illness, are more common in the 65 and over age group. Studies indicate that as high as 65 percent of the older population have experienced significant symptoms of depression at one time or another. (Jarvik, 1977; Epstein, 1976)

The relationship between depression and suicide has been well established. The seriousness of the problem for many older Americans is dramatically evidenced by the fact that 1 out of every 6 reported suicides in this country is committed by a person 65+. (National Center for Health Statistics, 1977) The relationship between depression and the growing problem of alcoholism in the population 65+ has been recently documented in a number of investigations. Alcoholism among persons 65+ has in the past been largely a hidden phenomenon but, as recent studies indicate, is a more substantial problem than previously realized. (National Institute on Alcohol Abuse and Alcholism, 1974; NIAAA, 1975)

Despite its prevalence and serious consequences, depression among the elderly has gone largely unrecognized and/or ignored by practitioners. It is sometimes mistakenly diagnosed as senility, or simply disregarded because its symptoms - such as sleep disturbances, muted affect, and slowness of response - are often an expected part of the behavior of older persons. Although the non-psychotically depressed elderly can often continue to live in the community (unlike many of those with senile dementia), they often do so at a painful price; significant numbers find life quite unendurable as the suicide statistics and rising rates of alcoholism reveal.

The above cited facts all argue for a greatly expanded research effort directed toward the causes, prevention, and treatment of depression in older persons. Research on depression in the elderly should address possible biological mechanisms as well as social and psychological factors. We also need to probe more deeply into the relative efficacy of various therapeutic approaches to depression currently available, including drugs, various types of one-to-one and group therapies, and ECT (electro-convulsive treatment). Current evidence suggests that contrary to many misconceptions, older people are quite able to respond to therapy and overcome depression if treatment is instituted early. One question to be examined concerns which treatment is best suited for particular individuals.

Because depression is a mental health problem currently undergoing considerable research scrutiny in the general population, it may in some instances be possible - and cost effective - to "piggy-back" studies on depression, suicide and alcoholism in older people by expanding the subject populations of current and proposed studies to include more of the elderly. Careful coordination within and among existing funding agencies and researchers will be required.

Recommendation III: Actions to develop a national data base on the epidemiology and demography of mental disorders of the elderly must be undertaken.

Discussion: If we are to serve the mental health needs of our older population well, we need to understand who and where they are, the particular mental health problems to which they are prone, the numbers affected, the long-term course and changing incidence of particular disorders, and the relation of mental health and illness patterns to service, manpower, training and research needs.

Such data are vital to the development of informed national policy, to provide a basis for meaningful manpower planning and deployment, and for sound evaluation of our service delivery systems. If such data-gathering is sustained consistently over a relatively long period of time, we may gain some clues from the past that may help us to anticipate future needs.

At present, our available data on the mental health and illness patterns among the elderly are sketchy at best. We know most about those who have already come in contact with the formal mental health system, particularly the institutionalized; we know relatively little about the community dwelling and those we most need to understand - older people who are now out of contact with the system, but in need of help.

While some community surveys have been conducted, we do not have a national data base on our community-dwelling elderly. Important geographic distinctions remain unknown, as do possible variances associated with economic social, racial and ethnic factors. An added problem has been the tendency in developing national statistics, whether census data or those pertaining to the mental health service needs and utilization, to lump all the elderly as "65 and older", rather than making finer age distinctions that might permit us to track important differences in mental health status at varying stages of the age continuum. Without such fine age distinctions, it is difficult to identify many age-related changes of importance to researchers and clinicians alike, such as the incidence and prevalence of senile dementia.

Greater support must also be given to developing national statistics on mental health service utilization by the elderly through cohort and trend analysis. By identifying and following defined groups of admissions over a specified time period, accurate data on length of stay in inpatient facilities and the long-term course of a particular mental disorder can be attained. The same approach could be applied to describing outpatient utilization patterns as well.

Recommendation IV: Research on mental health services, delivery systems and treatment interventions should be targeted for expanded support; such investigations should include the development of successful models and the evaluation of their effectiveness for differing populations.

Discussion: Mental health workers today possess a vast array of techniques for dealing with mental illness, encompassing social, behavioral, drug, electroconvulsive therapy and a host of counseling approaches. But, despite competing claims for the virtues of many different approaches, we know relatively little about the best match of treatments to patients, particularly the elderly. Although there is ample evidence that older persons react differently to specific treatments than do younger persons. There are also differential reactions within the elderly population itself. (Jarvik, 1977).

Without careful comparative study of treatment effects we needlessly risk wasting limited financial resources and hours of human effort ostensibly devoted to helping people. Carefully constructed and controlled long-term studies are needed that compare the efficacy of various treatment approaches with differing groups of elderly patients to determine which approaches are best suited to individual patients. Of particular importance are those methods of treatment that do not require long-term, expensive intervention by highly specialized personnel.

Equally important are studies comparing the impact of various forms of service delivery in defined populations. For example, one such research study might compare the effectiveness of conventional mental health centers vs. non-traditional sites in case-finding and treatment of older people. Another study might compare various forms of on-site comprehensive service delivery to older residents of hotels and/or special housing for the elderly.

A major objective of research programs examining intervention efficacy should be the development of program evaluation standards and guidelines. It is currently difficult to compare various programs, since each tends to use its own evaluative approaches and its own criteria. We need to develop, as some drug studies have done, standardized ways of describing the present problems of older people and dimensions of possible progress. Only then will researchers have a common basis for assessing their findings.

Recommendation V: Psychoparmacological Research: Investigations of the aging process as it effects differential responsiveness to drugs should be targeted for increased Federal support.

Discussion: As people age, many changes in normal physiological functioning occur that alter the metabolism and effects of drugs. Dosages that might be normal and effective with younger populations (those usually studied when appropriate dosage levels are established) may not be correct for older people. Adding to the complexity of drug therapy with older persons are frequent complications caused by the presence of other diseases and disabilities, and the possible interactive effects of ongoing drug treatments with new ones.

Drug therapy is perhaps the most frequent treatment intervention used with mentally ill older persons. Since little is known about appropriate dosage levels for this age group, adverse reactions of a serious nature are frequently encountered. We are particularly concerned with a current trend in many health care settings to overprescribe psychoactive drugs for mild mental health problems, with undue regard for their possible adverse side-effects. This is true both in outpatient settings and in long-term care institutions. Many of the latter still rely on "chemical restraint" to make difficult geriatric patients more tractable.

An additional problem which has not had sufficient study concerns the long-term effects of psychotropic medications. We are beginning to see a cohort of older people who have received psychotropic medication, whether tranquilizers, sedatives, or stimulants, for many years. We do not yet know whether such long-term administration of these drugs may have adverse effects that only show up after many years.

Underlying our understanding of drug effects in older people should be an expansion of basic research on normal physiological reactions of aging individuals to many types of drugs. Without this knowledge, we cannot be sure when our rich armamentarium of drug treatments is indeed best suited for aged patients.

A final area of important pharmacological investigation concerns possible chemical compensation for age-related deficits. Although a recent flurry of research on memory and learning enhancers has, to date, yielded no recognized benefits for the elderly, this avenue still remains a provocative one for future investigation.

Recommendation VI: Research efforts pertaining to the causation, prevention and amelioration of the major crises of later life should receive increased emphasis and support.

Discussion: All human beings throughout their life span are likely to encounter periods of severe crisis. As one ages, however, the number, frequency and interrelatedness of the crises of life increase immeasurably. Some of these crises are basically intrinsic to the aging process - declining physical capacity, chronic and/or catastrophic illness, and interpersonal losses; other crises, however, are imposed upon the aging individual by societal factors - forced retirement, diminished income, the loss of social roles and status, environmental barriers, and discriminations of various kinds.

All crises whether intrinsic to the aging process or societally included, can adversely affect the individual's ability to adjust successfully to his own aging experience, and frequently result in increased dependency and concomitant mental health problems. In the extreme, the inability to cope with the crises of later life undoubtedly contributes significantly to the alarming rate of suicide in the older population.

Research is urgently needed on the critical issues pertaining to the causation, prevention and amelioration of the major crisis episodes of later life, including the role of crisis as a precipitating factor in suicide. A number of primary issues need to be addressed: What are the factors which determine an individual's capacity to cope successfully during periods of crisis? What are the periods of highest risk? What is the role of sexual, ethnic and cultural factors in differential response to crises? What constitutes normal adjustment? What can be done to mitigate the adverse effects of stress-producing situations? The ultimate aim of this research is, of course, self evident: the identification of effective preventive measures and the development of successful programs of crisis intervention.

Recommendation VII: Research investigations of the causes, effects and ways to eliminate prejudicial attitudes toward the elderly should be expanded.

Discussion: As stated previously, ageism, like racism, is a complex form of prejudice toward a minority group, found not only among the young but the aged themselves, whose self-concepts may be damaged by many of the same negative stereotypes and attitudes toward aging characteristic of the young.

Although many theories have been advanced to explain ageism, we understand very little about its historical, social and psychological origins, or ways to eradicate it. Such studies are urgently needed if we are to respond adequately to the needs of the elderly and prevent yet another generation from experiencing unfounded discriminations, humiliations and fear at the very prospect of living long.

Of particular importance are studies which explore ways to change the attitudes of young and old alike toward aging and the aged. Some promising research leads exist; for instance, efforts are currently underway at the University of Maryland and elsewhere in which curriculum designed to develop more realistic images of aging has been introduced at the primary school level with encouraging results.

Studies aimed at developing more positive attitudes toward the elderly on the part of professionals and other "care-givers", who all too frequently avoid working with older persons, are also of prime importance. We need to know what changes in professional school curriculum and other training can bring this about. The role of the media in fostering negative images of aging also needs to be more fully evaluated. The potential of television for depicting the elderly in a more realistic manner likewise needs to be actively pursued.

Many years of effort and public education will probably be required to uproot this tenacious form of bigotry. One task for future researchers will be to analyze this rather global phenomenon, identify its causes and components, and suggest public policies likely to have the most direct effect in stimulating change.

Recommendation VIII: In order to pursue the expanded research effort described in the preceding recommendations, the capacities of existing Federal agencies to support research relevant to mental health of the elderly should be strengthened, while preserving a pluralistic, coordinated approach, especially in such areas as dementia research. While the National Institute of Mental Health should assume particular responsibilities for mental health research because of its basic mandate in this regard, the unique potentials of the National Institute on Aging and the Administration on Aging should also be enhanced.

Discussion: A number of Federal agencies currently support research related to aging, including the Administration on Aging, the National Institute on Aging, the National Institute of Mental Health, the National Institute of Neurological Diseases and Stroke, and the Veterans Administration. While each has its own particular mandate, the accomplishment of the research effort called for in the preceding recommendations will require strengthening the capacities of each of these agencies to support research relevant to the mental health of the aging.

Collaborative efforts should be encouraged as appropriate to accomplish the stated research goals; for example, the National Institute of Neurological Diseases, the National Institute on Aging and the National Institute of Mental Health should jointly mount a major national research effort to determine the causes, prevention and treatment of senile dementia.

While the research effort recommended in this report will involve strengthening the capacities of several Federal agencies in relation to mental health issues of aging, the Committee believes that the National Institute of Mental Health, because of its particular mandate to address mental health and mental illness, should undertake significant activity in this regard. At the same time, the unique strengthens and interests of the important new National Institute on Aging and the ongoing goals of the Administration on Aging should also be strongly supported in this area.

CHAPTER V

TRAINING

Effective mental health services for the elderly requires an adequate supply of individuals knowledgeable in mental health and aging to provide direct service, accomplish needed research, and train the necessary personnel. Many years of inattention to the mental health needs of older people have yielded a three-fold problem. First, we do not currently have available a sufficient number of practitioners in the health, mental health, and social service professions who have been specifically trained to address the mental health needs of the elderly - a situation likely to worsen as our older population grows, unless manpower development proceeds apace. Second, a sufficient supply of researchers with interest and expertise in research issues related to the mental health of the aging likewise does not exist. Third, we do not have the requisite number of geriatric mental health teachers and trainers needed to achieve the essential manpower supply. We cannot improve our service system nor increase our capacity to accomplish needed research unless there are well-trained, appropriately distributed personnel in sufficient numbers available.

Implementation of a national policy addressed both to upgrading the geriatric mental health competence of current practitioners, as well as ensuring an appropriate growth rate of well-trained individuals in the future is essential if we are to meet existing mental health service needs of our aged and prepare for those of the future. While the major focus of the Committee's recommendations concerns manpower and training needs in the mental health professions, accurate mental health manpower and training projections must take into account current and future roles and supplies of health and social service workers - both professional and paraprofessional - who work with the aged and aging. At the time of the 1971 White House Conference on Aging it was estimated that a third of a million professional and technical workers were employed in programs designed primarily or solely for older persons, and yet fewer than 10 to 20 percent of these people received any formal training for their work (Birren, 1977); to this day fewer still have had any exposure to mental health concerns.

Development of an adequate supply of trained personnel to meet the nationwide mental health needs of the elderly is dependent upon coordinated planning, programming, and appropriate funding at the Federal level to ensure that this occurs. The Committee, therefore, recommends that a training program, national in scope and Federally coordinated, be established in order that:

- o past deficiencies in training that currently impede effective several delivery and research investigations are redressed.

- o future capacity to assure an ongoing supply of competent personnel is developed.

- barriers to service that stem from misunderstanding and prejudice towards the elderly are removed.

The phasing and priorities of training and the establishment of guidelines for new manpower development should be formed by a careful analysis by HEW of current and projected service needs in relation to existing manpower supply and deployment.

The following recommendations provide the framework of a National Manpower and Training Program aimed at improving the quality and availability of specifically trained personnel to provide mental health services to the aging and accomplish needed research.

* * *

Recommendation I: Faculty Development: A national training effort to develop faculty with expertise in geriatric mental health in the major mental health, health, and social service disciplines should be initiated.

Discussion: Current manpower shortages in the field of aging and mental health are particularly apparent in the area of faculty. At present, our leadership resources are scanty. For example, information provided the Committee reveals that at the current time there are at best, 100 psychiatrists out of a total of 25,000 who have specialized expertise in geriatrics; there is but one medical school in the country with an endowed chair of Geriatric medicine.

The situation in other mental health, health and social service fields is markedly similar. If the mental health care needs of the Nation's elderly are to be met, it is urgent that these shortcomings be redressed. Simply stated, we cannot provide training without trainers. We must, thus, expand the geriatric mental health knowledge of existing teachers and practitioners, and provide them with effective curricular materials that can enhance their impact as educators and trainers.

Among the target groups of particular interest are faculty members in psychiatry, medicine, nursing, social work and psychology, as well as directors of inservice training in mental health and other institutions and facilities serving the elderly. Special incentives should be offered to encourage existing educators to obtain additional geriatric training and experience. The development of an increased number of faculty positions for those with geriatric mental health expertise should receive the requisite financial support.

In addition, training institutes in geriatric mental health should be sponsored to disseminate effective training approaches to potential educators and trainers. The creation of Comprehensive Training Centers, as proposed in Recommendation V, should provide an important resource for developing new specialists in geriatric mental health, many of whom will serve as teachers in the future.

Recommendation II: Practitioner Training: A national training effort should be initiated to enhance the geriatric mental health knowledge and skill of existing service providers in the mental health, health, and social service fields.

Discussion: Working with older people requires special sensitivity, skill, and knowledge. Despite years of professional training, most health, mental health, and social service professionals in their formal training receive little exposure to the particular problems of older persons. Consequently, many current practitioners who have not had access to geriatric training either avoid working with the aged or display undue pessimism in the face of actually treatable problems.

Without adequate training the risk of erroneous diagnosis and treatment is great. We are particularly concerned with correcting errors in differential diagnosis of senile dementia, acute brain disease, and depression, as well as excessive use of psychotropic medication.

A nationwide program of appropriate continuing education or inservice training for all practitioners whose work entails substantial involvement with the elderly must be inaugurated in order that the shortcomings in geriatric knowledge of current practitioners be corrected. Such training must address the needs of professionals and paraprofessionals alike in the various disciplines involved.

Two types of training programs for practitioners should be supported: 1) Continuing education courses in geriatric mental health for health, mental health, and social service professionals, which can compensate for earlier education deficiencies and provide up-to-date information on geriatric mental health; the key importance of providing appropriate training to family physicians in the differential diagnosis of geriatric mental health should be recognized. 2) Inservice geriatric mental health training programs for current staff and related personnel, paraprofessionals, and "other" service providers in institutions, organizations, and community agencies serving the elderly. It has been estimated that 80-90% of the care afforded the elderly in nursing home settings is provided by aides and orderlies (Senate, 1975); in 1975 tnese 375,000 individuals comprised over 60% of health related nursing home personnel. (National Center for Health Statistics, 1979). In-service training must address the needs of these personnel as well as those of nurses, other professionals and administrators alike.

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Inservice training as part of a comprehensive national effort should also be provided for such caregivers as senior center personnel and custodians of housing units since they are often the first point of contact for the elderly, and as such can serve as important referral agents to appropriate back-up services.

Recommendation III: The Training of New Manpower: Federal efforts to support the development and inclusion of geriatric mental health in the core curriculum and basic training of incoming personnel in all health, mental health and social service disciplines need to be expanded.

Discussion: Geriatric mental health training should be a part of the core curriculum for all incoming professional and support personnel in the health, mental health, and social service fields and should include practical experience for trainees in working with the elderly. Recent surveys, however, indicate that this is but a rare occurrence. For example, data furnished by the Health Resources Administration reveal that less than 1/2 of all medical schools in the country offer any elective course in geriatrics and only 54% of psychiatric residency training programs now provide any exposure to the disorders of the aged. Only 27 departments of psychology (14% of those responding to a nationwide survey) currently offer or are planning to establish graduate programs in aging and human development (American Psychological Association, 1976); nurses educated in gerontological nursing are a rarity in the U.S.

In order to correct current shortcomings, both quantitative and qualitative, support should be given to professional mental health training institutions and academic departments to stimulate the development and implementation of curricula in geriatric mental health. Incentives should be offered to encourage mental health training programs to offer practical experience in geriatric mental health care through linkages with local institutions and organizations serving the elderly. An additional area of support should be the development and implementation of geriatric mental health training programs as part of the basic staff training of all incoming support personnel in institutions serving the aged.

Recommendation IV: Specialist Training: A national training effort should be supported to develop a cadre of specialists in geriatric mental health.

Discussion: To develop a cadre of clinicians, teachers, researchers, and consultants who can provide expertise and leadership in mental health and aging, we must provide expanded opportunities for mental health professionals and others to become specialists in geriatric mental health.

At present we have but a handful of programs in the health and mental health disciplines combined, whether at the undergraduate, graduate, professional, internship or residency level, leading to the equivalent of a specialized degree (or subspecialty) in geriatrics; today's geriatric mental health "experts" are essentially self-taught.

Again, as already indicated, it has been estimated that there are at best a hundred psychiatrists in the entire country with expertise in the field of geriatric mental health. There is neither a specialty of geriatrics nor a subspecialty of geropsychiatry. In sharp contrast, professionals wishing to work with other age groups are provided the opportunity and training to do so, as the specialities of pediatrics, child, and adolescent psychiatry vividly demonstrate. The real dimensions and implications of the existing shortcomings in geriatric specialization are brought into sharp focus when one realizes that 1/3 of all patients seen by physicians specializing in internal medicine are over 65 (data provided by the Health Resources Administration), and that persons 65+ account for approximately 1/4 of the total personal health care expenditures annually in this country (Social Security Administration, 1977).

In order to accomplish the recommendations to follow, our capacity to provide specialized and/or advanced training must be stregthened.

Recommendation V: Comprehensive, Multidisciplinary Training Centers for Mental Health of the Aging should be created and supported on a regional basis. These centers should be affiliated with appropriate institutions having extensive research and service programs.

Discussion: Given the limited supply of specialists and trainers in geriatric mental health, existing manpower and talent must be used effectively and efficiently. The creation of Comprehensive Training Centers should facilitate this by establishing designated foci where experts can transmit their knowledge and skill to new trainees in an atmosphere intensively devoted to geriatric mental health.

These centers, located in or closely linked to institutions that have already shown research and service leadership and ability related to mental health and aging, are likely to have an existing core of expert faculty. However, funding from multiple sources will probably be required to expand the training skills of these faculty and staff members, and to augment their numbers to accommodate an expanded population of trainees.

Supplementing their direct training functions, the designated Comprehensive Multidisciplinary Training Centers should serve as a national resource for developing innovative curricula and teaching tools and disseminating improved approaches to geriatric mental health education and training. Among their functions should be the evaluation of existing training programs and the identification of gaps in Training.

In addition to providing Training for educators and direct service providers, the Comprehensive Training Centers should have the capacity to offer training in basic and applied research on mental health and aging. To mount and sustain a major research program on mental health and aging, as recommended in this report, we must have a cadre of scientists with specific skills and commitment to this research area. However, relatively few researchers in any scientific discipline are currently working on the geriatric research problems we have identified. As in the case of service manpower development, a dual strategy is needed: existing researchers must be attracted to enter this field while a new corps of geriatric mental health researchers is developed.

If Comprehensive Training Centers are located in or affiliated with institutions which already have ongoing, high-caliber research programs devoted to some of these problems, and their research training capabilities are further enhanced through faculty and trainee support, these centers can serve as magnets to attract both junior and senior researchers. The presence of research trainees, who learn largely by doing, should amplify the research capabilities of these centers.

Although some of the basic research and research training we view as crucial can be conducted in non-service settings, most of it is clinical research requiring skills best obtained in a research setting closely allied with service delivery. The presence in the same setting of research, service, and training all related to a well-delineated area of concern - in this case, mental health and aging - has proven repeatedly to have a synergistic effect for all three activities.

Recommendation VI: Content in mental health and aging should be included as a required component of countinuing education in programs related to licensure, relicensure, certification, or recertification of health and mental health professionals.

Discussion: There is a growing tendency for professional organizations and state licensing bodies to require health and mental health professionals to participate in continuing education throughout their careers. Strong pressures are also mounting to require these practitioners to demonstrate their professional knowledge and skill through periodic certification and recertification examinations. All of these pressures are intended to ensure that these service personnel keep abreast of current knowledge and good practice. There has been little effort to date, however, to use these quality control mechanisms to ensure that current mental health practitioners are knowledgeable and skilled in the particular area of mental health and aging.

If, as we have proposed, expanded training programs are offered in geriatric mental health for incoming professional trainees, the level of professional competence in this essential service area should improve in the future. However, to ensure that today's and tomorrow's practitioners, indeed, possess the requisite knowledge and skill to provide quality mental health care to the aged, they should be required, at the very least, to show that they have updated and amplified their geriatric mental health knowledge and skill through participation in relevant continuing education.

We would prefer to see standard-setting bodies representing the professions themselves develop and enforce standards that will ensure that all mental health professionals have some basic training and knowledge in geriatric mental health. However, additional Federal pressures may be needed if these are not forthcoming.

CHAPTER VI

MINORITIES

Whatever problems aging brings for members of our majority culture, these are compounded for many elderly minority group members. Older persons are known to have relatively high rates of mental illness; available evidence indicates that elderly minority group members may have even higher rates. Certainly the conditions of their lives place them at particularly high risk, as the following facts vividly illustrate:

- Although a disproportionate number of older Americans are poor - in 1977 approximately 1 out of 7 live in poverty - minority elderly are, on the average, more than twice as likely to be poor.
- Although elderly women living alone represent the most proverty-stricken group among the older population, with 1 out of 3 so classified, elderly minority women are even more disadvantaged: more than 2 out of 3 now live in poverty. (Bureau of Census, 1976)
- Although fear of crime is considered a "very serious" problem by 1 out of 5 older white Americans, it is a very serious problem for 2 out of 5 black aged.
- Loneliness is a "very serious" problem for 1 out of 10 older whites - it is so classified by nearly 1 of 4 black aged. (National Council on the Aging, 1975)
- Although older persons in general experience more chronic health problems than do younger individuals, the physical health status of elderly minority group members is even poorer - more than twice as many minority elderly report their health as being poor than do elderly whites. (National Center for Health Statistics, 1976)

Despite the obvious need for special attention to the problems of minority group elderly, all available evidence indicates that older minority group members are even less likely to receive adequate and appropriate health and mental health care than older whites. Our fragmented service system creates particularly serious difficulties for minority elderly who are even more likely than whites to suffer from multiple problems.

Although some progress has been made since the 1971 White House Conference, major inequities, shortcomings, and service barriers continue to exist. Furthermore, the many ethno-cultural differences not addressed under the generic label "minority" continue to remain largely ignored.

Many of the general recommendations in this report, if implemented, should reap benefits for minority group members as well as other elderly persons. However, we believe that the special situation of minority elderly requires specific attention in the form of the following recommendations.

Recommendation I: Federally funded research and demonstration projects should be established at selected sites throughout the country to explore methods for better serving the mental health needs of elderly minority group members and to conduct research on specific minority aging issues.

Discussion: The minority elderly share many characteristics in common with other older Americans, but many features of their lifestyles, attitudes, cultural values, language, and socio-economic and educational status require special consideration.

Although minority elderly often suffer from multiple handicaps and problems, they currently receive relatively little in the way of mental health services in proportion to their need, and frequently confront service providers who do not understand their particular perspectives and problems. It is particularly important with this segment of our population that we accomodate our service system to those served, rather than ask that they change the habits, attitude and expectations of a lifetime to suit a service system often oriented toward and staffed by representatives of the mainstream culture. For example, elderly minority group members tend to be particularly leery of psychiatric services, explicitly so labeled, and may be better served in a general health care or social service context; analysis of health care utilization data reveals that elderly minority group members rely heavily on outpatient services rather than those which are institutional-based, a factor which must also be taken into account in any service system addressed to their needs.

If we are to adequately serve the mental health needs of elderly minorities, it is obvious that services and programs must become more responsive to their particular needs and life styles. The Committee, therefore, recommends that Federally funded research and demonstration projects be established at selected sites throughout the country to systematically evaluate the critical factors involved in the delivery of mental health services to minority group aged.

The research and demonstration programs should be based in locations which serve heavy concentrations of members of a particular minority group - be it Black, Hispanic, Oriental, or another of the Nation's many ethnic groups. Although their primary concern should be improved mental health services to minority group elderly, these programs should be closely linked administratively to organizations and research groups concerned with overall issues affecting minority group members of all ages. The project team should include professional members of the minority group in question.

The establishment of such research and demonstration programs, designed and evaluated with the participation of those for whom they are targeted, provides a vehicle for systematically exploring new models of improved service delivery. If successful, they can be applied in other locales with similar populations. However, unless there are adequate health care financing mechnisms in place that facilitate the continuation and expansion of such programs by providing financial access to services, we will not have accomplished the intent of these recommendations - to establish a service system that is continuously responsive to all segments of the aging population. The creation of model programs that last only as long as Federal funding holds out must not become an end in itself.

Recommendation II: The development of strategies for ensuring better access to service for elderly minority group members needs to be pursued by all Federal agencies.

Discussion: As the facts presented on the previous pages vividly reveal, elderly minority group members represent a particularly vulnerable population, from both physical and mental health perspectives. They are especially likely to be poor, and may well bear the medical and mental scars of a lifetime of inadequate nutrition, health care and social opportunity. Old age adds further losses and stresses to the indignities and illnesses of the past. The great vulnerability of many minority group members is statistically evident, both in terms of greater susceptibility to mental and physical illness and in the differential mortality rates for white vs. non-whites.

Ideally, we should have a service system which is readily accessible to all. And ideally, minority group members should have access to lifelong living conditions and health care which might assure survival rates comparable to those of the now more advantaged majority. At present, however, recognizing that we are far from achieving these ideals, our best course of action is to define eligibility for existing benefits with sufficient flexibility to assure that we do not exclude from our service system those who need it most. Defining eligibility for Medicare benefits for example on the basis of age 65 ignores the fact that because minority group members live shorter lives, they are often in need of services geared to the "aged" at a relatively early point in the life cycle. A proposed solution of particular value to the mental health of minority elderly would be to provide Medicare coverage for all persons over 50 years of age receiving SSI benefits.

Recommendation III: Data collection systems in all Federal programs serving the elderly should include provision for reporting of age (by sub-categories), sex, race, and ethnic origin.

Discussion: An essential part of any effective service system is information about the people it does or should serve. At present we have inadequate data concerning our older population's service needs and utilization patterns. We are particularly deficient concerning older members of minority groups - especially those other than blacks. Important ethno-cultural differences remain unknown. What data do exist, however, indicate that all minority elderly groups are notably underserved by our current mental health system.

An improved system of data-gathering, which includes provision for reporting of age, sex, and ethnic origin, in all Federal programs for the elderly might have several benefits for minority group members: a) it can provide a means of assessing whether intended target populations have actually been reached; b) it can suggest needed programmatic changes to correct service gaps; c) it can serve as a means of "consciousness-raising" among service staff, administrators, and planners; and d) it can contribute to a sufficiently large data base to permit meaningful statistical comparisons and analyses to be made concerning groups of service users. From such data we may be able to develop a more precise statistical picture of how members of particular minority groups are faring in our service system.

The Committee members recognize the potential for resistance to this proposal - both by some clients who are wary of labeling and potential discrimination and/or invasion of privacy, and by some service personnel who fear more paperwork. But we feel that it is possible to obtain essential service data judiciously, without hardship to the servers or the served. The need for such data is critical to effective service delivery.

Recommendation IV: The nationwide training program in mental health and illness of the elderly, recommended by the Committee, should make a substantial effort to develop specialized training for serving minorities. In addition, grants-in-aid, scholarships, and fellowship programs should be offered to stimulate minority participation in training for geriatric mental health research, service, and education.

Discussion: Minority participation in the mental health and geriatric fields, particularly at the professional levels, is growing, but still relatively small. For example, data provided by the American Psychiatric Association reveals that in 1977 there were only 400 black psychiatrists in the entire country. Currently only two percent of psychiatric residents are black, a production rate unlikely to compensate for many years of under-represenation in medicine and psychiatry. Our supply of other minority mental health workers is comparably small, and those with special geriatric expertise infinitesimal.

It is evident that we cannot and should not expect the mental health needs of older minority group members to be met by minority personnel alone. Therefore, all who work with minority elderly should be adequately trained to understand their special problems, perspectives, and needs. However, the need for greater representation and participation of minority group members in service occupations necessitates a specific effort to stimulate minority recruitment and training. The Federal Government should, therefore, earmark specific funds in the form of grants-in-aid, scholarships and fellowship programs to stimulate minority participation in the field of geriatric mental health.

Recommendation V: Advisory groups and other bodies responsible for evaluating and initiating public programs serving minority elderly should include representation by minority specialist in the aging and mental health fields.

Discussion: At present there are relatively few individuals with expertise in geriatric mental health serving in critical evaluative, advisory, and decision-making positions affecting the current and future course of Federal programs for the aged. It is essential that this situation be redressed if the mental health care needs of the elderly are to be adequately considered in the national decision-making process.

The lack of representation by minority group members who are geriatric mental health experts on national advisory bodies is even more striking. Their presence is essential to assure that minority rights, needs, and issues are appropriately represented in Federal decision-making concerning the aged. A "core" of minority group experts in mintal health and aging currently exists from whic to draw this expertise. Adequate minority representation on these bodies requires, of course, that their number be expanded, a goal addressed in the preceding recommendation.

CHAPTER VII

MAJOR STRATEGIES FOR IMPLEMENTATION

The Committee's recommendations presented in this report cover a wide range of issues within its overall mandate to examine the needs for services, research and training important to the mental health needs of the elderly. While necessarily selective, the Committee concentrated on those factors most specific to the understanding of mental illness and the improvement of the mental health status of the elderly. If implemented as a cohesive whole, these recommendations will provide an integrated approach to improving the mental health care of the Nation's elderly.

The Committee, as previously indicated, recognizes that these changes cannot occur overnight, and that planning and phasing-in must occur. It was felt to be beyond the scope of our one-year time-limited mandate, however, to delineate specific plans and timetables for implementation. The Committee viewed its major task as developing an overall body of interrelated recommendations. One of our recommendations, however, the creation of a National Commission on Mental Health and Illness of the Elderly establishes the mechanism by which implementation of the overall recommendations will be facilitated.

The Committee believes that the recommendations presented in this report provide the basic framework for subsequent effective planning and implementation to occur. Because implementation involves coordination at so many levels and by so many groups, it will take time. Five to ten years would be a reasonable period in which to realize some of the basic changes. But this does not mean five to ten years are needed to pass the necessary legislation, or to make policy changes. Such actions must be of relative immediacy. Five to ten years is envisioned as the required time frame after legislation and policy changes make it possible to start.

The recommendations set forth in this report primarily address required actions at the Federal and to some degree State levels. It is also recognized, however, that to be effective, a wide variety of planning models are needed to implement local level activities. Again, however, specific local actions were felt to be beyond the scope of the Committee's mandate.

All of the recommendations (each set of recommendations) envision both more appropriate utilization of current resources as well as new resources. We believe that the existing Federal financing mechanisms could be more effectively used to: 1) maintain the mental health and self-sufficiency of the elderly; and, 2) meet the needs for care of the mentally ill and/or chronically disabled elderly, if there is agreement on and commitment to:

- a national policy regarding mental health services for the elderly, based on the recommendations of this Committee; and

- A location of authority and responsibility for implementing the national policy and laying the groundwork for development of a coordinated administrative structure for carrying out existing, modified, and new mental health services mandated by the national policy.

Thus, the basic framework for implementing the recommendations contained in this report are dependent upon the fulfillment of the following three major strategies:

I. Changes in existing laws to broaden the provisions for mental health services for the aged.

II. Fuller use of existing legislative authorities and programs to enhance the knowledge and develop the capacity for delivery of mental health services to the aged.

III. Establishment of a National Commission on Mental Health and Illness of the Elderly.

* * *

I. CHANGES IN EXISTING LAWS TO BROADEN THE PROVISIONS FOR MENTAL HEALTH SERVICES FOR THE AGED

A. Changes in Medicare and Medicaid

In Medicare and Medicaid, the two current programs that pay for facets of medical care for most elderly persons, there are restrictions concerning the scope of mental health benefits and the definition of mental health providers. These restrictions serve to limit and distort the kind, extent, and availability of mental health care for the elderly.

Although the Medicare and Medicaid programs provide the elderly with more complete third-party payment coverage of medical costs than any other age grouping in this country, these resources have not supported the development of comprehensive mental health services for the elderly. The restrictions in both programs, particularly those on outpatient services, have contributed to many service gaps. The emphasis on institutional care has meant that most of the Medicare and Medicaid expenditures relate to the mentally ill elderly in nursing homes and mental hospitals. (Morris Associates, 1975; Krueger, 1977). Too little attention has been given to the potentials of Medicare and Medicaid and other Federal programs designed to develop health and social service resources in providing preventative, rehabilitative and supportive services for the elderly mentally ill.

Short of a comprehensive national health insurance plan for the total population, the best way to provide medical care, including mental health care, for the elderly is to expand Medicare to cover a broader range of mental health and general health services, and to eliminate current restrictions concerning mental health services and providers. With such an arrangement, a residual Medicaid program covering older persons would be needed to pay for the co-insurance and deductibles for the elderly indigent as well as for long-term care services not covered by Medicare.

In order to make the Medicare and Medicaid benefit programs more responsive to the needs of the mentally ill elderly, the following recommendations will need to be enacted:

1) Amend the Medicare and Medicaid legislation to extend the same coverage and benefits for mental illness that are now available for physical illness.

For Medicare:

Under Part A, eliminate the present 190-day lifetime limitation on inpatient care in psychiatric hospitals.

Under Part B, eliminate the present $250 per year outpatient care limitation for physician services for treatment of mental illness.

Include the services needed by mentally ill persons in the definition of need for skilled nursing care and for home health services.

For Medicaid:

Make clinic services, including ambulatory mental health care, a mandatory service to be covered in the State plan.

Remove the age restriction on coverage of inpatient psychiatric care in order to make this benefit available to aging persons under 65.

2) Amend the Medicare and Medicaid legislation to place the providers of mental health services on an equal basis with the providers of general health services. Specifically:

Special attention should be given to the explicit role of community mental health centers as providers of inpatient, ambulatory, rehabilitative, and in-home services. Federal provider standards need to be developed that reflect the unique nature of the community mental health center, and the fact that direct mental health care is provided by several mental health professions, i.e., psychiatrists, psychologists, social workers, and nurses.

Federal provider requirements and standards need to be modified for skilled nursing facilities, intermediate care facilities, home health agencies and comprehensive day care service programs to recognize their role as providers of mental health serives.

3) Strengthen the quality assurance mechanisms built into Medicare and Medicaid to include the mental health components in staff requirements, provider qualifications and professsional review of services. Specifically:

Staff qualifications, licensure standards, and continuing education requirements should include the need for specific knowledge and expertise in providing mental health care for the elderly.

Survey and certification procedures should make appropriate use of mental health experts in assessing provider qualifications and compliance with Federal regulations.

Within Professional Standards Review Organizations, specialized review of mental health services in inpatient, long-term care, and ambulatory settings should be required.

4) Add new benefits for all Medicare patients that would be of particular value to patients with mental disorders. This would include reimbursement for:

Professional assessment of the individual's need for care, and for assistance to the individual in obtaining needed services.

Day care treatment; expanded home health services; health counseling services (including nutrition counseling) and rehabilitation services.

All prescription drugs; eyeglasses, hearing aids; and foot care.

5) Extend Medicare entitlement to all recipients of Supplementary Security Income who are 50 years and older and disabled.

Enactment of this recommendation would provide a more equitable coverage for aging individuals who are unable to work. It would be particularly beneficial to members of minority groups because of their shorter life expectancy.

Provisions would be made in Medicaid to provide for Federal payment of deductibles and co-insurance for this newly covered group and to reimburse long-term care services not covered by Medicare.

B. Changes in the Health Planning and Resources Development Act

This national planning legislation is concerned with achievement of equal access to quality health care, the better distribution of resources, planning for health services and facilities, and with authorization of financial assistance for the development of resources. The law provides for Health Systems Agencies to carry out these functions at the local level, through a health systems plan and an annual implementation plan. There are also provisions for policy development at the State and Federal levels.

The Health Systems Agencies are potentially a major resource in ensuring that comprehensive and coordinated health care is provided at the local level. However, the Health Systems Agencies are not presently required to place emphasis on mental health services, or the elderly, or to consider these areas in their annual plan.

1) Amend the National Health Planning and Resources Development Act of 1974 to provide that Health Systems Agencies are responsible for assuring the inclusion of mental health services and resources needed by the elderly in their health systems plans and annual implementation plans.

C. Changes in Title XX of the Social Security Act

"Grants to States for Services", Title XX of the Social Security Act, provides funds to the States for social services for recipients of income-tested cash payments programs, e.g., Supplementary Security Incomes, and to other low-income persons. Its potential as a resource for increasing the availability of needed services for older persons who are mentally ill could be considerable. A major stated program goal is the development of services to promote independent living. Specifically, the purpose of this legislation is to encourage each State to furnish services directed toward:

Achieving or maintaining economic self-support and self-sufficiency.

Preventing or remedying neglect, abuse or exploitation of persons unable to protect their own interests and preserving rehabilitating or reuniting families.

Preventing or reducing inappropriate institutional care by providing for community-based, home-based, or other less intensive forms of care.

Securing referral or admission for institutional care when other forms of care are not appropriate; providing services to individuals in institutions.

Supportive services covered include transportation, homemaker services, chore and shopping assistance, protective services, meals on wheels, and supervised living arrangements. Although the States are given great latitude by the Federal government to decide which social services will receive support, the majority have given little or no consideration to the adequate inclusion of mental health services in their Title XX programs. Many of the services covered by Title XX are not now available to clients of the mental health system. If they were, the danger of inappropriate institutionalization -- or deinstitutionalization without the provision of appropriate community care -- would be lessened considerably.

1) Amend Title XX of the Social Security Act to require that social support services necessary for comprehensive mental health care be a component of the State Social Service Plan.

Since Federal financing of Title XX sets a limit on the amount of Federal funds available to the States in a given fiscal year, it may take some modification of the ceiling on Federal funds for Title XX to provide needed mental health services.

D. Changes in the Older Americans Act

The Older Americans Act sets forth a list of objectives for older people which cuts across all areas of Federal programming and mandates certain programs within the Administration on Aging, including research and demonstration, training, nutrition support and community services. Of particular interest is Title III, "Grants for State and Community Programs on Aging", which is designed to encourage and assist State and local agencies in the development of comprehensive and coordinated systems of social services to persons age 60 and over. The provisions of Title III are of considerable import for serving the needs of the mentally ill elderly and for establishing a mechanism whereby coordinated service can be delivered.

The social support programs include transportation and escort services, outreach, counseling, health related services, preventive services (which include periodic screening and evaluation, homemaker and home health services, chore services, friendly visiting services, telephone reassurance, protective services and housing assistance), recreation, continuing education, legal services, welfare services, nutrition, employment, information and referral services. To qualify for the benefit of available services, persons must be 60 years or older. There are no other eligibility requirements.

Area Agencies on Aging came into being in 1973 as a result of the amendments of the Older Americans Act creating Title III. The law provides for the AAA's to serve as planning bodies and to develop annual plans under which they can fund service programs operated for older people by local service providers. Much of their effort is directed toward coordinating existing service programs, tapping unused resources, and acting as advocates for older people in their areas.

The funding and coordination of mental health services, however, is currently not mandated as a requirement of either State or area plans.

1) Amend Title III of the Older Americans Act to provide that the State and Area Agencies on Aging are responsible for the inclusion of mental health services in their State and area plans.

Financial and technical assistance should be provided to assist in staff and resource development.

II. MAKING FULLER USE OF EXISTING LEGISLATIVE AUTHORITIES

A wide range of Federal legislative authorities and progams already exists that should be used as resources to implement the recommendations contained in this report to ensure the mental health and well-being of the elderly. Major legislative provisions that include these authorities are: the Public Health Service Act, the Social Security Act, the Older Americans Act, and Veterans Administration legislation.

All of these legislative authorities and programs have the potential for increasing our knowledge about the mental health problems of the aging and improving our abilities to prevent or minimize disabilities and deterioration and our capacity to meet their needs for care.

* * *

One of the most serious gaps in the provision of mental health services to the elderly is the lack of effective mechanisms in communities for developing comprehensive care systems and making them available to individuals. Although promising models do exist, further research and demonstration is needed to develop and evaluate the effectiveness of alternative systems of care.

Authorities for research and experimentation on the delivery of health services currently exist in the Social Security Act and the Public Health Service Act. These and other legislative authorities could be effectively utilized to fund such research and demonstration efforts as:

Alternative models for meeting the mental health care needs of elderly persons in different community and geographic settings.

Methods of identifying high risk groups of elderly persons and making prevention and therapeutic services available to them.

Utilization of the family as a resource; provision of financial and other incentives to enlist the participation of family members in the care of the frail elderly.

Development and utilization of community mental health centers to provide leadership in the coordination and delivery of mental health services to the elderly.

1) Existing legislative authorities should be used to provide expanded support to experimentation and demonstration of improved methods of delivery of mental health services.

A number of legislative authorities likewise exist for support of the Committee's research and training recommendations, particularly those in the National Institute of Mental Health, the National Institute on Aging, the Health Resources Administration, the Administration on Aging, and the Veterans Administration. However, current as well as past support of research and training pertaining to mental health and aging has been minimal under these existing authorities.

2) Each Federal program with legislative authority to support or carry out research and/or training should devote an appropriate proportion of their efforts to problems of mental health and illness of the aging.

Consideration should be given to designating a specific percentage of total research and training funds for this purpose in each Federal program with such legislative authority.

III. ESTABLISHMENT OF A NATIONAL COMMISSION ON MENTAL HEALTH AND ILLNESS OF THE ELDERLY

There are many Federal programs that are concerned directly or indirectly with the mental health needs of the aging - each with a separate administrative structure and funding mechanism. To accomplish the recommendations set forth in this report a Federal focal point for the development of a national policy on coordinating services, research, training, and staff development in mental health and aging is clearly needed.

1) The Congress should establish a National Commission on Mental Health and Illness of the Elderly.

The Commission should be established for a five-year period and be responsible for: a) developing a national policy and the required short- and long-term planning required to implement the recommendations of this Committee, and, b) overseeing a program of coordinated mental health services for the aged.

The major contributions of the National Commission would be to bring about legislative and policy changes as rapidly as possible, to require agencies and programs involved to develop plans for implementation, and to establish data collection and reporting systems which would provide both a better picture of the changing needs and status of the elderly as well as monitor progress toward stated goals.

Several of the legislative authorities mentioned in this report are now being reviewed in anticipation of their renewal or modification. The Commission could play a vital role in this process and ensure that appropriate emphasis is given to the needs of the elderly in legislative proposals. The Commission would also work closely with the Federal Council on the Aging and, by giving special attention to the solution of problems faced by the elderly mentally ill, would enrich the broad leadership provided by the Council.

The Commission should assume a major role in ensuring that the development of national policy on mental health services for the elderly is based on comprehensive data on the aged population, their mental health needs, the services they are now receiving, and the costs of these services. Ongoing programs now collect data in keeping with the requirements of their own legislation and program needs. As a result, they have different population coverage, data elements, and definitions.

2) The Commission should give special attention to the quality and comparability of statistical data on the aged (e.g., their health, mental health, and social status and needs, and types and costs of health and mental health services utilized) that are now collected by each of the Federal programs concerned with the general health and mental health needs of the aging population.

Support for a National Commission or similar entity has come from a number of sources over the years:

> The 1971 White House Conference on Aging recommended "at an early date there be established a Presidential Commission on Mental Illness of the Elderly with responsibility for implementing recommendations of the Conference".
>
> In 1971 the Senate's Special Committee on Aging issued a report "Mental Health Care of the Elderly: Shortcomings in Public Policy" recommending legislation to establish such a Commission.

The Senate report and its recommendation were endorsed by such groups as the American Psychiatric Association, the American Psychological Association, and the Group for the Advancement of Psychiatry.

In 1974 Senator Muskie introduced legislation to establish a Presidential Commission on Mental Health of the Elderly, noting the lack of progress im meeting the mental health needs of the elderly.

Although the Commission has yet to become a reality, the above cited actions did result in the establishment of the current one-year Committee whose report is herein presented. One-year is clearly insufficient time to devote to this important problem, however. The need for a Commission still exists in order that the recommendations of this Committee be translated into effective policy and action. The problems are known, the challenge is great - but the solutions are attainable.

EXECUTIVE SUMMARY

RECOMMENDATIONS

A. Prevention

The Committee recommends that:

1) Effective systems for teaching the elderly to cope with the aging process be developed. Expanded support should be given to exploring and applying effective strategies for disseminating this knowledge through the media care providers, educational institutions, senior citizen groups, and other community organizations.

2) Programs that provide the elderly with the opportunity for new and/or continued community roles and activities receive increased emphasis and support.

3) Increased support be given to the development, dissemination, and expansion of effective models of preretirement and post-retirement education programs, in cooperation with industry, unions, colleges, universities, and senior citizen and voluntary organizations.

4) A major program of public education be developed to combat prejudice toward the old and to improve the image of the aging experience in the eyes of the general public, the media, service providers and the elderly themselves. Actions to combat age discrimination in all its aspects should be vigorously pursued.

5) To help provide appropriate services and avoid unwarranted institutionalization, a nationwide system of Comprehensive Geriatric Assessment Units be created within existing community programs to serve as assessment, assignment, treatment, and coordinating centers on an area-wide basis.

6) Crisis intervention programs at the community level be developed and expanded to provide services for the elderly who are at high risk of developing mental illness.

7) A comprehensive, long-term social support system be developed in each community for elderly persons who are chronically ill, socially isolated, and/or frail which can provide, on a sustained basis, those services needed to promote and maintain maximum levels of functioning. Existing agencies and organizations should be used to the fullest extent possible, while new models must be designed and tested to ensure that present gaps in services are closed.

8) The most vulnerable groups of community dwelling elderly be entitled to special assistance in planning for and access to the services they need: the deinstitutionalized chronically mentally ill and those with severely reduced physical and emotional capacities due to extreme old age. Federal support should be given to developing and testing models for sustained community agency responsibility for regularly monitoring and assuring needed services for these high-risk elderly.

B. Services

The Committee recommends that:

1) In order to improve the availability and accessibility of mental health care for elderly persons, coverage for mental health services be provided on an equal basis with coverage for physical health care services, for both acute and chronic illnesses. In existing third-party programs, current inequities in coverage for mental health care services must be redressed, making mental health care services as accessible as physical health care services, for both acute and chronic illnesses.

2) A national policy to ensure the availability of a full-range of mental health services for the elderly, ranging from ambulatory to home health, congregate living, day and/or night care, transitional care (half-way houses), foster homes, rehabilitative services, and specialized inpatient services be developed.

3) In order to provide quality mental health services to the elderly, staff of health and mental health providing specialized services to the elderly have specific expertise and training in geriatric mental health care. Regulations governing third-party payments to such facilities as community mental health centers of other comprehensive mental health programs, public or private mental hospitals, or university-operated or affiliated teaching hospitals should require that these institutions demonstrate adequate staff training as a condition of provider eligibility.

4) Staff development and inservice training costs be an allowable item for Medicare and Medicaid reimbursement up to five percent of total service delivery costs.

5) In long-term care facilities, mental health services be regularly provided to all patients having significant mental

disorders, either directly by the facility or by an outside agency by written agreement.

6) A focal point be designed at the State level to ensure that the mental health needs of the elderly are being and will be met through careful assessment, coordination, and planning of statewide health, mental health and social services. Financial and technical assistance should be provided to States to strengthen their capacity for geriatric mental health service assessment, coordination, planning and development.

C. Research

The Committee recommends that:

1) An expanded national research program on the causes, treatment and prevention of senile dementia and on changes in intellectual functioning and/or ability in later life be supported.

2) An expanded research effort to determine the causes, treatment and prevention of depression in older persons including investigations of the relationships of depression to suicide, alcoholism and other symptomatic and behavioral disorders be initiated.

3) Actions to develop a national data base on the epidemiology and demography of mental disorders of the elderly be undertaken.

4) Research on mental health services, delivery systems and treatment interventions be targeted for expanded support; such investigations should include the development of successful models and the evaluation of their effectiveness for differing populations.

5) Psychopharmacological research - investigations of the aging process as it effects differential responsiveness to drugs - be targeted for increased Federal support.

6) Research efforts pertaining to the causation, prevention and amelioration of the major crises of later life receive increased emphasis and support.

7) Research investigations of the causes, effects, and ways to eliminate prejudicial attitudes toward the elderly be expanded.

8) In order to pursue the expanded research effort described in the preceding recommendations, the capacities of existing Federal agencies to support research relevant to mental health of the elderly be strengthened, while preserving a pluralistic, coordinated approach, especially in such areas as dementia research. While the National Institute of Mental Health should assume particular responsibilities for mental health research because of its basic mandate in this regard, the unique potentials of the National Institute on Aging and the Administration on Aging should also be enhanced.

D. Training

The Committee recommends that:

1) A national training effort to develop faculty with expertise in geriatric mental health in the major mental health, health, and social service disciplines be initiated.

2) A national training effort be initiated to enhance the geriatric mental health knowledge and skill of existing service providers in the mental health, health, and social service fields.

3) Federal efforts to support the development and inclusion of geriatric mental health in the core curriculum and basic training of incoming personnel in all health, mental health, and social service disciplines be expanded.

4) A national training effort be supported to develop a cadre of specialists in geriatric mental health.

5) Comprehensive, Multidisciplinary Training Centers, for Mental Health of the Aging be created and supported on a regional basis. These centers should be affiliated with appropriate institutions having extensive research and service programs.

6) Content in mental health and aging be included as a required component of continuing education in programs related to licensure, relicensure, certification, and recertification of health and mental health professionals.

E. Minorities

The Committee recommends that:

1) Federally funded research and demonstration projects be established at selected sites throughout the country to explore

methods for better serving the mental health needs of elderly minority group members and to conduct research on specific minority aging issues.

2) The development of strategies for ensuring better access to services for the elderly minority group members be pursued by all Federal agencies.

3) Data collection systems in all Federal programs serving the elderly include provision for reporting of age (by subcategories), sex, race, and ethnic origin.

4) The nationwide training program in mental health and illness of the elderly, recommended by the Committee, make a substantial effort to develop specialized training for serving minorities. In addition, grants-in-aid, scholarships, and fellowship programs should be offered to stimulate minority participation in training for geriatric mental health research, service and education.

5) Advisory groups and other bodies responsible for evaluating and initiating public programs serving minority elderly include representation by minority specialists in the aging and mental health fields.

F. Major Strategies for Implementation

The Committee recommends that:

1) The Medicare and Medicaid legislation be amended to extend the same coverage and benefits for mental illness that are now available for physical illness.

2) The Medicare and Medicaid legislation be amended to place the providers of mental health services on an equal basis with the providers of general health services.

3) The quality assurance mechanisms built into Medicare and Medicaid be strengthened to include the mental health components in staff requirements, provider qualifications and professional review of services.

4) New benefits for all Medicare patients be added that would be of particualr value to patients with mental disorders.

5) Medicare entitlement be extended to all recipients of Supplementary Security Income are 50 years and older and disabled.

6) The National Health Planning and Resources Development Act of 1974 be amended to provide that Health Systems Agencies are responsible for assuring the inclusion of mental health services and resources needed by the elderly in their health systems plans and annual implementation plans.

7) Title XX of the Social Security Act be amended to require that social support services necessary for comprehensive mental health care be a component of the State social service plan.

8) Title III of the Older Americans Act be amended to provide that the State and area agencies on aging are responsible for the inclusion of mental health services in their State and area plans.

9) Existing legislative authorities be used to provide expanded support to experimentation and demonstration of improved methods of delivery of mental health services.

10) Each Federal program with legislative authority to support or carry out research and/or training devote an appropriate proportion of their efforts to problems of mental health and illness of the aging.

11) The Congress establish a National Commission on Mental Health and Illness of the Elderly.

12) The Commission give special attention to the quality and comparability of statistical data on the aged (e.g., their health, mental health, and social status and needs, and types and costs of health and mental health services utilized) that are now collected by each of the Federal programs concerned with the general health and mental health needs of the aging population.

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APPENDICES
(Secretaries Committee MHIE)

Appendix A

Organizations Submitting Written Recommendations to Committee in Response To National Survey

State Departments of Health/Mental Health

State of Alaska Department of
Health and Social Services
Pouch H 01
Juneau, Alaska 99811

State of Florida Department of Health
& Rehabilitative Services
1323 Winewood Boulevard
Tallahassee, Florida 32301

State of Idaho Department of Health
and Welfare
Region II Mental Health Services
608 North State Street
Grangeville, Idaho 83530

Commonwealth of Kentucky
Department for Human Resources
Frankfort, Kentucky 40601

Louisiana Health & Human Resources
Administration
Human Resources
150 Riverside Mall
Baton Rouge, Louisiana 70801

The Commonwealth of Massachusetts
Department of Mental Health
190 Portland Street
Boston, Massachusetts 02114

State of New Mexico Department of
Hospitals and Institutions
113 Washington Avenue
Santa Fe, New Mexico 87501

State of Oklahoma
Oklahoma Public Welfare Commission
Department of Institutions, Social and
Rehabilitative Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125

State of Tennessee Department of
Mental Health and Mental Retardation
501 Union Building
Nashville, Tennessee 37219

Texas Department of Mental Health and
Mental Retardation
Texas Research Institute of Mental
Sciences
1300 Moursund, Texas Medical Center
Houston, Texas 77030

The Commonwealth of Virginia
Department of Mental Health
and Mental Retardation
P.O. Box 1797
Richmond, Virginia 23214

State Offices on Aging

State of Connecticut Department of
Aging
90 Washington Street
Hartford, Connecticut 06115

State of Delaware Division of Aging
2413 Lancaster Avenue
Wilmington, Delaware 19804

State of Illinois Department on Aging
2401 West Jefferson Street
Springfield, Illinois 62706

Council on Aging/State of Mississippi
510 George Street
Jackson, Mississippi 39216

State of New Jersey Department of
Community Affairs/Division on Aging
363 West State Street
Trenton, New Jersey 08625

State of North Carolina Department
of Human Resources
Office for Aging
213 Hillsborough Street
Raleigh, North Carolina 27603

Aging Services
North Dakota State Capitol
Bismarck, North Dakota 58505

South Carolina Commission on Aging
915 Main Street
Columbia, South Carolina 29201

Tennessee Commission on Aging
306 Gay Street
Nashville, Tennessee 37201

Commonwealth of Virginia
Office on Aging
830 E. Main Street
Richmond, Virginia 23219

Other Government Offices

Top of Alabama Regional Council of Governments
Central Bank Building, Suite 350
Huntsville, Alabama 35801

City of Jackson
Senior Citizens' Information and Referral
326 South Street
Jackson, Mississippi 39201

Commonwealth of Virginia
House of Delegates
2256 North Wakefield Street
Arlington, Virginia 22207

Veterans Administration Department of Medicine & Surgery
Mental Health and Behavioral Sciences
810 Vermont Avenue N.W.
Washington, D.C. 20520

Voluntary Organization/Advocacy Groups

American College on Nursing Home Administrators
4650 East-West Highway
Washington, D.C. 20014

American Nurses' Association, Inc.
2420 Pershing Road
Kansas City, Missouri 64108

The American Orthopsychiatric
Association, Inc.
1775 Broadway
New York, New York 10019

American Psycholosical Association
1200 17th St., N.W.
Washington, D.C. 20036

Family Service Association of America
44 East 23rd Street
New York, New York 10010

Family Service of Milwaukee
P.O. Box 08517
Milwaukee, Wisconsin 53208

Family Service of Montgomery
County, Inc.
One West Deer Park Road
Suite 201
Gaithersburg, Md. 20760

International Committee Against
Mental Illness
40 East 69th Street
New York, New York 10021

Mental Health Association on
Central Middlesex, Inc.
103 Old Road to Nine Acre Corner
Concord, Massachusetts 01742

Mental Health Association of Georgia, Inc.
85 Merritts Avenue, N.W.
Atlanta, Georgia 30308

Public Interest Law Center of Philadelphia
1315 Walnut Street
Philadelphia, Pennsylvania 19107

Sister Kenny Institute
811 East 27th Street
Minneapolis, Minnesota 55407

Universities

University of Illinois at the Medical
Center, Chicago
833 South Wood Street, P.O. Box 6998
Chicago, Illinois 60680

Boston University
Gerontology Center
730 Commonwealth Avenue - 4th Floor
Boston, Massachusetts 02215

Smith College
School of Social Work
Lilly Hall
Northampton, Massachusetts 01063

Washington University in St. Louis
The George Warren Prown School of
Social Work
St. Louis, Missouri 63130

Community Mental Health Facilities/Other Community Programs

ALABAMA

Wiregrass Mental Health Center
P.O. Drawer 1245
104 Prevatt Road
Dothan, Alabama 36301

Marshall-Jackson Mental Health Center
Jackson County Center
P.O. Box 914
Scottsboro, Alabama 35768

ARIZONA

Phoenix-South Community Mental Health Center
5 North 8th Avenue
Phoenix, Arizona 85007

CALIFORNIA

Kern View Community Mental Health
Center and Hospital
3600 San Dimas Street
Bakersfield, California 93301

Veterans Administration Hospital
3801 Miranda Avenue
Palo Alto, California 94304

District V. Community Mental Health/Geriatric Services
2101 20th Avenue
San Francisco, California 94116

Westside Community Mental Health
Center, Inc.
2201 Sutter Street
San Francisco, California 94115

Los Angeles County-Olive View Medical Center
14445 Olive View Drive
Sylmar, California 91342

San Fernando Valley Community
Mental Health Center
10930 Sherman Way
Van Nuys, California 91406

Mental Health Services for Tulare County
1830 South Mooney Blvd.
Vidalis, California 83277

COLORADO

Mental Health Center of Boulder County, Inc.
Boulder Valley Office
1333 Iris Avenue
Boulder, Colorado 80302

Weld Mental Health Center, Inc.
1306 Iris Avenue
Greeley, Colorado 80631

Arapahoe Mental Health Center, Inc.
Littleton Office
6640 South Broadway
Littleton, Colorado 80120

CONNECTICUT

The Wheeler Clinic, Inc.
91 Northwest Drive
Plainville, Connecticut 06062

FLORIDA

Mental Health Center of Polk County, Inc.
1745 Highway 17, South
Bartow, Florida 33830

Gerontology Program
Northwest Florida Mental Health Center, Inc.
P.O. Box 4810
Panama City, Florida 32401

Palm Beach County Comprehensive Community
Mental Health Center, Inc.
1041 45th Street
West Palm Beach, Florida 33407

GEORGIA

Comprehensive Mental Health Center
P.O. Box 5087
Savannah, Georgia 31403

ILLINOIS

Kane-Kendall County Mental
Health Center
400 Mercy Lane
Aurora, Illinois 60505

Edgewater Upton Community Mental
Health Council
1004 West Wilson Avenue
Chicago, Illinois 60640

Ben Gordon Community Mental Health Center, Inc.
637 South First Street
DeKalb, Illinois 60115

Mental Health Center of LaSalle County
1000 East Norris Drive
Ottawa, Illinois 61350

KANSAS

Johnson County Mental Health Center
6000 Lamar Avenue
Mission, Kansas 66202

Concord Area Mental Health Center
119 Old Road to Nine Acre Corner
Concord, Massachusetts 01742

Gardner-Athos Mental Health Center
13 Elm Street
Gardner, Massachusetts 01440

Dr. Harry C. Solomon Mental Health Center
391 Varnum Avenue
Lowell, Massachusetts 01854

Bay Coye (Tufts) Mental Health Center
West Broadway Unit
62 Joyce-Hayes Way
South Boston, Massachusetts 02127

MICHIGAN

Community Mental Health Board
407 W. Greenlawn
Lansing, Michigan 48910

MISSISSIPPI

Regional Mental Health Center
Highway 7 Bypass South
P.O. Box 1137
Oxford, Mississippi 38655

The Jackson Mental Health Center
989 Lakeland Drive
Jackson, Mississippi 39216

MISSOURI

Southeastern Jackson County Mental Health Center
769 Tudor Road
Lee's Summitt, Missouri 64063

MONTANA

South Central Montana Regional Mental Health Center
1245 North 29th
Billings, Montana 59101

NEVADA

Las Vagas Mental Health Center
6161 W. Charleston
Las Vagas, Nevada 89102

NEW HAMPSHIRE

Project Comet
15 Garrison Avenue
Durham, New Hampshire 03824

NEW JERSEY

Central Bergen Community Mental Health
Center
18 Park Place
Paramus, New Yersey 07652

NEW YORK

Albert Einstein College of Medicine of
Yeshiva University
Sound View-Throgs Neck
Community Mental Health Center
2527 Glebe Avenue
Bronx, New York 10461

Rensselaer County Mental Health Department
Unified Services
33 Second Street
Troy, New York 12180

Mercy Hospital of Watertown/Madonna Home
Health Related Facility
218 Stone Street
Watertown, New York 13601

NORTH CAROLINA

Halifax County Mental Health Center
P.O. Drawer 1199
210 Smith Church Road
Roanoke Rapids, North Carolina 27870

Wilson-Greene Mental Health Center
1709 Tarboro Street, S.W.
Wilson, North Carolina 27893

NORTH DAKOTA

The Center for Human Development
509 South Third Street
Grand Forks, North Dakota 58201

OHIO

Tuscarawas Valley Comprehensive Mental
Health Services, Inc.
201 Hospital Drive
P.O. Box 279
Dover, Ohio 44622

Jefferson County Comprehensive Mental
Health Center
St. John Heights
Steubenville, Ohio 43952

OKLAHOMA

State of Oklahoma Department of
Mental Health
Carl Albert Mental Health Center
P.O. Box 579
11th and Monroe
McAlester, Oklahoma 74501

OREGON

Community Mental Health Consultant, Inc.
1857 University Street
Eugene, Oregon 97403

PENNSYLVANIA

Irene Stacy Community Mental Health Center
112 Hillvue Drive
Butler, Pennsylvania 16001

Crozer-Chester Medical Center
Upland
Chester, Pennsylvania 19103

Westmoreland Hospital Association
Westmoreland Hospital Community
Mental Health Center
532 West Pittsburg Street
Greensburg, Pennsylvania 15120

Community Mental Health/Mental Retardation Center
1800 West Street
Homestead, Pennsylvania 15120

North Central Philadelphia Community Mental
Health/Mental Retardation Center
3701 N. Broad Street
Philadelphia, Pennsylvania 19140

Community Mental Health/Mental Retardation Center
Consultation/Education Unit
South Hills Health System
Old Clairton Road and Audrey Drive
Pittsburg, Pennsylvania 15236

Divine Providience Hospital
1100 Grampian Blvd.
Williamsport, Pa. 17701

SOUTH CAROLINA

York-Chester-Lancaster Mental
Health Center
12- York Street
Chester, South Carolina 29706

Pee Dee Mental Health Center
Route 2, Box 7
Florence, South Carolina 29501

TENNESSEE

Dede Wallace Center/Madison Branch
223 Madison Street, Suite 208
Madison, Tennessee 37115

TEXAS

Austin-Travis County Mental Health-
Mental Retardation Center
1430 Collier
Austin, Texas 78704

Dallas County Mental Health/Mental Retardation Center
District V Adult Health Center
329 Colorado
Dallas, Rexas 75203

Tropical Texas Center for Mental Health
and Mental Retardation
P.O. Drawer 1108, 1425 South 9th
Edinburg, Texas 78539

Bexar County Mental Health-Mental
Retardation Center
2415 W. Southcross
San Antonio, Texas 78211

UTAH

Salt Lake County
Murray-Jordan-Tooele Mental Hygiene Centro
5130 South State Street, Suite B
Murray, Utah 84107

Weber County
Golden Hours Center
650 25th Street
Ogden, Utah 84401

Salt Lake Community Mental Health Center
807 East South Temple
Salt Lake City, Utah 84102

VERMONT

Mental Health Services of Southeastern Vermont, Inc.
19 Westminister Terrace
Bellows Falls, Vermont 05101

VIRGINIA

Woodburn Center for Community Mental Health
3340 Woodburn Road
Annandale, Virginia 22003

Community Mental Health Center and
Psychiatric Institute
721 Fairfax Avenue
P.O. Box 1980
Norfolk, Virginia 23501

WASHINGTON

The Eastside Community Mental Health
Center, Inc.
2253 140th Avenue, N.W.
Bellevue, Washington 98005

Mid-Columbia Mental Health Center
1175 Gribble
Richland, Washington 99352

WEST VIRGINIA

The Appalachian Mental Health Center
Yokum and Wilmoth Streets
Elkins, West Virginia 26241

Community Mental Health Center, Inc.
Region II, University Heights
3375 U.S. Rte. 60 East, P.O. Box 8069
Huntington, West Virginia 25705

Southern Highlands Community Mental
Health Center
12th Street Extension
Princeton, West Virginia 24740

Northern Panhandle Mental Health Center, Inc.
2121 E. Off Street
Wheeling, West Virginia 26003

WISCONSIN

Unified Mental Health, Alcoholism and
Drug Abuse Board
County Trunk NN - Mail Box 290
Walworth County
Elkhorn, Wisconsin 53121

APPENDIX

Individuals and Organizations Attending Public Meeting of April 15, 1977 at Which Draft Recommendations Were Presented and Comments Requested.

Public Attendees

American Federation of Retired Persons
National Retired Teachers Association
1909 K Street, N.W.
Washington, D.C. 20049
Tom Elwood

American Hospital Association
444 N. Capital Street, N.W.
Suite 500
Washington, D.C. 20001
Goodrich Stokes

American Nurses' Association, Inc.
2420 Pershing Road
Kansas City, Missouri 64108
Gloriana J. Arceneaux

American Psychiatric Association
1700 18th Street, N.W.
Washington, D.C. 20009
Ron McMillian

Association of University Programs
in Health Administration
1755 Massachusetts Avenue N.W., Suite 312
Washington, D.C. 20036
Grace Goodman

Coalition of Spanish Speaking Mental
Health Organizations (COSSMHO)
1725 K Street, N.W., Suite 1212
Washington, D,C, 20006
Carmen Meneses

Gerontological Society
#1 Dupont Circle, N.W.
Washington, D.C. 20036
Rosemary Yancik
Patricia Carter

Home Health Services Of D.C.
2007 Eye Street, N.W.
Washington, D.C. 20006
Glenda Motta

Hospital & Community Psychiatry Journal
of the American Psychiatric Assoc.
1700 18th Street, N.W.
Washington, D.C. 20009
Barbara Armstrong

Morris Associates
Dupont Circle, N.W.
1346 Connecticut Avenue N.W., #931
Washington, D.C. 20036
Stephanie Mensh

National Association of State
Mental Health Program Directors
1001 3rd Street, S.W., Suite 114
Washington, D.C. 20024
Roy Marshall

National Council on Aging
1828 L Street, N.W.
Washington, D.C. 20036
Marjorie Collins

Plus Publications
2626 Pennsylvania Ave., N.W.
Washington, D.C. 20037
Nancy Keebler

Prince George's County Health Dept.
Hospital Road
Cheverly, Maryland 20785
Hazel Newell

Resources News Service
655 National Press Building
Washington, D.C. 20045
Deborah Stewart

Skokie Office of Aging
4436 Oakton Street
Skokie, Illinois 60076
Peggy W. Gilmore

Washington Representative Services
2430 Pennsylvania Ave., N.W.
Washington, D.C. 20037
Wayne Kelley

U.S. Government Attendees

United States Department of Health, Education, and Welfare

Administration on Aging

G. Sandra Fisher
Richard Kopanda
Richard Schloss

Administration for Public Services

James J. Burr

Federal Council on the Aging

Muriel Shurr

Health Care Financing Administration

James Baker
Willie Ethridge
Terry Riley

Health Services Administration

Ronald Ausbrooks
Lee W. Smith

National Institute on Aging

Jessie Gertman
Gail Jacoby

National Institute of Mental Health

Thomas Anderson
Robert Arrindell
Leona Bachrach
Marie Blank
Alvira Brands
Marian Ciampa
Gene Cohen, M.D.
Barry Lebowitz
Enid Light
George Popz
Judity Turner

U.S. House of Representatives, Select Committee on Aging

Elliot Stern

U.S. Senate, Special Committee on Aging

William Oriol

Individuals Testifying at other Meetings of Committee

Dr. Faye G. Abdellah
Assistant Surgeon General
Chief Nurse Officer
Public Health Service
U.S. Dept., HEW
Rockville, Md.

Dr. Stanley Brody
Professor
Dept. of Rehabilitative Medicine
University of Pennsylvania
Philadelphia, Pennsylvania

Dr. Bertram S. Brown
Director
National Institute of Mental Health
U.S. Dept. of H.E.W.
Rockville, Maryland

Dr. Robert Butler
Director
National Institute of Aging
U.S. Dept. H.E.W.
Bethesda, Maryland

Dr. Jack Ewalt
Director
Mental Health and Behavioral
Sciences Services
Veterans Administration
Washington, D.C.

Mr. Byron Gold
Director
Office of Research, Demonstration and
Manpower Resources
Administration on Aging
U.S. Dept. H.E.W
Washington, D.C.

Dr. Barbara Herzog
Special Assistant to the Executive Director
National Retired Teachers Association/American Association
of Retired Persons
Washington, D.C.

Dr. Steven Sharfstein
Acting Director
Community Mental Health Services Programs
National Institute of Mental Health
Rockville, Maryland

Dr. Bruce Sloan
Chairman
Department of Psychiatry
University of Southern California
Los Angeles, California

Mr. William Oriol
Staff Director
U.S. Senate Special Committee on Aging
Washington, D.C.

APPENDIX

Public Law 94-63, July 29, 1975 - Committee on Mental Health and Illness of the Elderly.

Sec. 603. (a) The Secretary of Health, Education, and Welfare shall appoint a Committee on Mental Health and Illness of the Elderly (hereinafter in this section referred to as the "Committee") to make a study of and recommendations respecting-

(1) the future needs for mental health facilities, manpower, research, and training to meet the mental health care needs of elderly persons,
(2) the appropriate care of elderly persons who are in mental institutions or who have been discharged from such institutions, and,
(3) proposals foe implementing the recommendations of the 1971 White House Conference on Aging respecting the mental health of the elderly.

(b) Within one year from the date of enactment* of this Act the Secretary shall report to the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives the findings of the Committee under the study under subsection (a) and the Committee's recommendations under such subsection.

(c) (1) The Committee shall be composed of nine members appointed by the Secretary of Health, Education, and Welfare. The Committee shall include at least one member from each of the fields of psychology, psychiatry, social science, social work, and nursing. Each member of the Committee shall be training, experience, or attainments be exceptionally qualified to assist in carrying out the functions the Committee.

(2) Members of the Committee shall receive compensation at a rate to be fixed by the Secretary, but not exceeding the daily equivalent of the annual rate of basic pay in effect for grade GS-18 of the General Schedule, for each day (including traveltime) during which they are engaged in the actual performance of duties vested in the Committee. WHile away from their homes or regular places of business in the performance of services for the Committee, members of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 (b) of title 5 of the United States Code.

(d) The Committee shall cease to exist thirty days after the submission of the report pursuant to subsection (b).

* Amended to "Not later than August 30, 1977 (H.R. 49-75, Amendment #186) 5/11/77.

APPENDIX D

1971 White House Conference on Aging
Mental Health Care Strategies and Aging - Recommendations

1. It is recommended that at an early date, there be established a Presidential Commission on Mental Illness and the Elderly, with responsibility for implementing recommendations made at the White House Conference on Aging. It smember should be appointed by the President, subject to the advice and consent of the Congress.

2. It is recommended that a Center for the Mental Health of the Aged be established within the National Institute of Mental Health, with the authority and funds for research, training, and innovative programs for older people in the community and in hospitals.

3. It is recommended that there be recognition and support of each older individual's right to care and treatment in any one of the wide range of alternative mental health services now existing, or those that will be developed.

4. It is recommended that there be universal prepaid, comprehensive health insurance including coverage for mental illness and health.

5. It is recommended that inequities and discrimination with respect to the financing of mental services should be eliminated from Medicare and Medicaid. There should be prompt elimination of deductible and co-insurance features; and inclusion of drugs, currently excluded dental care and prosthetics under medicare.

6. It is recommended that Medicaid funds should be properly used as legally prescribed; this should be guaranteed by adequate Federal supervision and enforcement.

7. It is recommended that all funds allocated by the Congress for research, training and services for the elderly should be released and distributed promptly both now and in the future, with speedy cooperation of the Executive Branch of the government where required. (See recommendation on the appointment of a Presidential Commission.)

8. It is recommended that efforts should be made at Federal, State, and local levels to develop options to institutional care.

9. It is recommended that adequately staffed and programmed comprehensive mental health diagnostic and treatment centers be developed in neighborhood health centers, community mental health centers, hospitals and other appropriate local, geographically accessible settings; special attention to adequate funding is of prime importance.

10. It is recommended that properly staff inpatient or residential facilities with proper programs should be available in adequate number; all of these should have available methods of supervising, caring for, and protecting persons in their own homes for as long a period as medically and socially possible for the patient.

11. It is recommended that more attention be given to the development of innovative therapeutic services to currently institutionalized older persons, and for the future care of persons in need of protective environments as inpatitnts or residents in congregate settings.

12. It is recommended that research monies for studies of aging and the elderly, from basic biological processes to social and psychological phenomena, be greatly increased.

13. It is recommended that all mental health programs foe the elderly be open to all, without a "means test." This mandates adequate funding.

14. It is recommended that there be recognition that training and education of the necessary health professionals is urgently indicated. Such health manpower must be increased in number as well as quality. Again, adequate funding is a necessity.

15. We are aware that there is a large body of factual and technical data on aging and the practical treatment of the disorders in the elderly which is not generally available and known. Therefore, it is recommended that material describing the best comprehensive care methods in a variety of settings should be prepared, widely distributed and their availability made known.

16. It is recommended that the proposed Presidential Commission, or another appropriate government agency, look into the methods of purchase and provision of mental health care currently undertaken by Federal, State, and local governments, in order to advise as to what is most economical and effective.

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